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SUPREME COURT  
STATE OF WASHINGTON

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BY RONALD R. CARPENTEI

Case No.: 89664-0

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SUPREME COURT  
FOR THE STATE OF WASHINGTON

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LEONARD ALBERT, M.D., PhD, and Jeff Summe, D.O.

Appellants,

v.

STATE OF WASHINGTON, DEPT OF LABOR & INDUSTRIES

Respondent.

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BRIEF OF APPELLANTS

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Shawn Timothy Newman  
WSBA 14193  
Attorney at Law, Inc. P.S.  
2507 Crestline Dr., N.W.  
Olympia, WA 98502  
PH: (360) 866.2322  
FAX: 1.866.800.9941  
shawn@newmanlaw.us  
Attorney for Dr. Albert

Randolph I. Gordon  
WSBA 8435  
Law Offices of  
Randolph Gordon, PLLC  
1218 Third Ave.  
Suite 1000  
Seattle, WA 98101  
randy@randygordonlaw.com  
PH: (425) 454-3313  
FAX: (425) 646-4326  
Attorney for Dr. Summe

Attorneys for Appellants

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## A. INTRODUCTION

This case concerns the Department of Labor and Industries' decision to terminate providers of medical care for injured workers without securing an order per RCW 51.52.075.<sup>1</sup> Absent such an order, the Department is stayed from discontinuing provider services to injured workers, both because the statute mandates such a hearing and because the Department's order is not final pending review by the independent Board of Industrial Insurance Appeals [BIIA]. The Department argued that the new Provider Network established by RCW 51.36.010<sup>2</sup> rendered the old system and RCW 51.52.075 moot.<sup>3</sup> Further, the Department argued that since the providers were not part of the new Network there was no "termination"<sup>4</sup> although it sent an "**Urgent**" notice to covered patients that "This provider cannot continue to treat your workers' compensation injury".<sup>5</sup>

## B. ASSIGNMENTS OF ERROR

1. Did the Trial Court err in concluding that RCW 51.52.075 does not apply to denial of eligibility to participate in the Medical Provider Network?

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<sup>1</sup> A-1

<sup>2</sup> A-2

<sup>3</sup> CP 155 [fn. 5]

<sup>4</sup> RP 31:13 et seq.

<sup>5</sup> A-3; CP 26-27 [Emphasis in original letter]; RP 16:17-25; RP 22:20 et seq.

2. Did the Trial Court err in concluding that the Plaintiffs do not have a constitutional interest or a vested right in treating injured workers?

**C. ISSUES PRESENTED**

1. Is the Department required to follow RCW 51.52.075 before it discontinues provider services to injured workers?  
(Assignment of Error #1)
2. Is the Department stayed from discontinuing provider services pending final order by the Board of Industrial Insurance Appeals?  
(Assignment of Error #2)
3. If so, did the Department violate Article 1, section 3 of the Washington State Constitution by depriving providers of liberty and property interests without due process?  
(Assignment of Error #2)

**D. STATEMENT OF THE CASE**

**1. Legislative History**

The Department's Medical Provider Network was created under the 2011 amendments to RCW 51.36.010.<sup>6</sup> RCW 51.36.010 did not repeal or amend RCW 51.52.075. RCW 51.52.075 states:

**Appeal from order terminating provider's authority to provide services; Department petition for order immediately suspending provider's eligibility to participate.**

When a provider files with the board an appeal from an order terminating the provider's authority to provide services related to the treatment of industrially injured workers, the department may petition the board for an order immediately suspending the provider's eligibility to participate as a provider of services to industrially injured

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<sup>6</sup> A-2; CP 146

workers under this title pending the final disposition of the appeal by the board. The board shall grant the petition if it determines that there is good cause to believe that workers covered under this title may suffer serious physical or mental harm if the petition is not granted. The board shall expedite the hearing of the department's petition under this section.<sup>7</sup>

The Washington Final Bill Report,<sup>8</sup> 2004 Reg. Sess. S.B. 6428, for what became RCW 51.52.075, states:

If the Department of Labor and Industries (L & I) suspends a provider's eligibility to provide services to industrially injured workers and the provider appeals the suspension order to the Board of Industrial Insurance Appeals (BIIA). L & I's suspension order is stayed pending the outcome of the appeal. As a result of the stay, the provider can continue to provide workers' compensation health services.

Based upon this Final Bill Report, Substitute Senate Bill 6428 was enacted, passed unanimously by the House with the unanimous concurrence of the Senate. It became law: RCW 51.52.075, 2004 Wash. Laws c 259 § 1, eff. June 10, 2004.<sup>9</sup>

The Department's Network rules are found at WAC 296-20-01010 to 01100. The Department's commentary on those rules includes the following:

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<sup>7</sup> A-1

<sup>8</sup> A-4; CP 110-114

<sup>9</sup> A-5; CP 110-116

The appeal rights that apply to any Department action remain in effect and contain the process for further appeal. These rules do not limit this process.<sup>10</sup>

....

The Department has consistently indicated and been advised that other statutory provisions, namely appeal rights contained in RCW 51.52 remain unaffected. The Department agrees to clarify explicitly that health care provider network decisions, such as denial or removal, are appealable under RCW 51.52.<sup>11</sup>

**Rule Change:** The Department made one clarifying change to indicate that the health care provider network decisions are subject to appeal under RCW 51.52.<sup>12</sup>

WAC 296-20-01100(2) states:

It is not the intent of the department to remove or otherwise take action when providers are practicing within department policies and guidelines, or within best practices established or developed by the department, or established in collaboration with its industrial insurance medical and chiropractic advisory committees.

Prior to establishment of the Network in 2013, the Department followed

RCW 51.52.075.<sup>13</sup>

## **2. Factual Background**

### **a. The Appellant Physicians**

#### **i. Dr. Albert<sup>14</sup>**

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<sup>10</sup> A-6 [Concise Explanatory Statement for WAC 296-20-01010 to 01100; Overall Rule Comments]; CP 110-112; 122; RP 15:9-25

<sup>11</sup> A-6; CP 110-112; 136 [WAC 296-20-01090]

<sup>12</sup> A-6; CP 136. That would include RCW 51.52.075.

<sup>13</sup> A-1; CP 23-24; 35-40 [Dr. Lance Christiansen]; RP 13:18 et seq.

<sup>14</sup> See CP 102-105

Dr. Leonard Albert, M.D., Ph.D. is board certified in anesthesiology, internal medicine and as a medical examiner. He operates an internal medicine and pain management practice in Shelton, Washington, and has been an approved provider for injured workers since 1981.<sup>15</sup>

On December 20, 2012, Dr. Albert's application to participate in the Department of Labor and Industries' [DLI] Medical Provider Network was denied [i.e. "Denial Letter"]<sup>16</sup>

On January 30, 2013, Dr. Albert appealed to the Board of Industrial Insurance Appeals [BIIA].<sup>17</sup>

On February 6, 2013 the Department reassumed jurisdiction to reconsider its decision.<sup>18</sup>

On February 11, 2013, BIIA returned the case to the Department for further action.<sup>19</sup>

On February 26, 2013, the Department affirmed its decision to deny Dr. Albert's application.<sup>20</sup> The Department's final order became effective on March 16, 2013. Dr. Albert appealed.<sup>21</sup>

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<sup>15</sup> CP 5; 33-34; 90

<sup>16</sup> A-7; CP 6; 15; 21

<sup>17</sup> A-8; CP 6; 91

<sup>18</sup> CP 6; 91

<sup>19</sup> CP 6; 91

<sup>20</sup> A-7; CP 6; 91

<sup>21</sup> CP 6; 91

The Department sent a notice entitled “Urgent Action Required” to clients who are injured workers that Dr. Albert will no longer be eligible for coverage.<sup>22</sup> Further, the Department sent notice of the application denial to the National Practitioner Data Base stating that the physician “does not meet Dept. credentialing requirements”; noting the length of action is “indefinite”; and that the physician will not automatically be reinstated.<sup>23</sup> The Denial Letter states:

*Are you eligible to reapply to join the provider network?*

Your eligibility to reapply depends on the reason for your denial and is found in WAC 296-20-01070. You are eligible to reapply to the network after five (5) years, unless you were denied from network participation due to:

- Finding of risk of harm<sup>24</sup>
- Excluded, expelled or suspended, other than for convenience, from any federally or state funded programs
- Convicted of a felony or pled guilty to a felony for a crime and felony has not been expunged from the provider’s record
- Sexual misconduct as defined in profession specific rules of any state or jurisdiction<sup>25</sup>

None of these apply to Drs. Albert or Summe because the Department did not follow RCW 51.52.075 and make any such finding. On March 19,

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<sup>22</sup> A-3; CP 6-7; CP 26-27

<sup>23</sup> A-9; CP 7; 22; 30-31

<sup>24</sup> See RCW 51.52.075

<sup>25</sup> A-7; CP 28-29

2013, Dr. Albert appealed to BIIA.<sup>26</sup> That appeal is pending but does not encompass the issues presented here.

**ii. Dr. Summe<sup>27</sup>**

Dr. Jeff Summe, D.O. is board certified in Family Practice and Suboxone Certified in treating addiction. He operates a Family Practice in Edmonds, Washington, and has been an approved provider for injured workers since 1990. The Department of Labor & Industries accorded Dr. Summe the coveted “Active” status of an Independent Medical Examiner (IME) in the Workers’ Compensation system as recently as October 29, 2012.<sup>28</sup>

On January 29, 2013, Dr. Summe’s application to participate in the Department of Labor and Industries’ [DLI] Medical Provider Network was denied.<sup>29</sup>

On February 22, 2013, Dr. Summe sought reconsideration of the decision.<sup>30</sup>

On April 12, 2013, the Department reaffirmed its decision.<sup>31</sup>

On April 16, the Department sent a notice entitled “Urgent Action Required” to clients who are injured workers that Dr. Summe will no

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<sup>26</sup> CP 7

<sup>27</sup> See CP 106-109

<sup>28</sup> CP 5; 15; 90

<sup>29</sup> A-7; CP 7; 91

<sup>30</sup> CP 7; 91

<sup>31</sup> A-7; CP 7; 91

longer be eligible for coverage.<sup>32</sup> Further, as with Dr. Albert, the Department sent notice of the application denial to the National Practitioner Data Base.<sup>33</sup> On April 29, 2013, Dr. Summe appealed to BIIA.<sup>34</sup> That appeal is pending but does not encompass the issues presented here.

**b. Constitutional Concerns**

Drs. Albert and Summe applied to the Department to join the Network.<sup>35</sup> They meet the “Minimum health care provider network standards” set forth in WAC 296-20-01030. They are “practicing within department policies and guidelines, or within best practices established or developed by the department.”<sup>36</sup>

A physician applying with the Department to join the Network has no hearing or opportunity to be heard.<sup>37</sup> The Department’s Denial Letter form states:

This decision will become final 60 days after you receive this notice unless a written request for reconsideration is filed with the Department of Labor and Industries or an appeal is filed with the Board of Industrial Insurance Appeals.<sup>38</sup>

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<sup>32</sup> A-3; CP 6-7; 26-27, 91

<sup>33</sup> A-9; CP 7; 91

<sup>34</sup> CP 7; 91

<sup>35</sup> CP 102-109 [Declarations of Dr. Albert and Dr. Summe]

<sup>36</sup> See WAC 296-20-01100(2)

<sup>37</sup> See, CP 28-29; 56-61.

<sup>38</sup> A-7; CP 28-29

Nevertheless, 30 days after that notice, the Department sent letters directly to Drs. Albert's and Summe's patients. The form letter is entitled "**Urgent Action Required**" and states that "This provider cannot continue to treat your workers' compensation injury."<sup>39</sup>

Furthermore, the Denial Letter states that "upon the effective date, the department is required to report this application denial to the National Practitioner Data Bank." The Department that Drs. Albert and Summe "Failed to meet department credentialing requirements as specified in Washington Administrative Code."<sup>40</sup> Although both doctors appealed to the Board of Industrial Insurance Appeals, the Department suspended their eligibility to participate as providers of services to industrially injured workers pending the final disposition of the appeal.<sup>41</sup>

Dr. Albert immediately raised due process concerns.<sup>42</sup> His counsel, Shawn Newman, subsequently raised specific concerns that the Department violated due process by failing to secure an order per RCW 51.52.075 prior to terminating Dr. Albert as a qualified provider.<sup>43</sup> On

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<sup>39</sup> A-3; CP 26-27 [Emphasis in original letter]; RP 16:17-25; RP 22:20 et seq.

<sup>40</sup> A-9; CP 21-25; 30-31

<sup>41</sup> CP 8

<sup>42</sup> A-8; CP 32 ["I protest your denial of my joining the medical network for injured workers in Washington State. This is based on a Washington state Supreme Court decision in the *Nguyen versus Washington State Medical Quality Assurance Commission*." Referring to *Nguyen v. State, Dept. of Health*, 144 Wn.2d 516, 522, 29 P.3d 689 (2001).

<sup>43</sup> CP 7; 23

July 17, 2013, Assistant Attorney General Michael Throgmorton informed Mr. Newman, that any challenge on the grounds of procedural due process would have to be considered by the Superior Court and would not be adjudicated by the Board of Industrial Insurance Appeals.<sup>44</sup>

Industrial Appeals Judge Janice A. Grant confirmed to Doctor Summe's counsel, Randolph Gordon, in a telephonic hearing on June 20, 2013, that any challenge on the grounds of procedural due process would have to be considered by the Superior Court and would not be adjudicated by the Board of Industrial Insurance Appeals.<sup>45</sup>

On July 31, 2013, Industrial Appeals Judge Wm. Andrew Myers confirmed that the scope of the appeal before the Board of Industrial Insurance Appeals did not, without a motion to expand the issues, include the applicability of RCW 51.52.075.<sup>46</sup> Judge Myers confirmed that the Board would not have jurisdiction over tort claims concerning the availability of monetary damages for violation of RCW 51.52.075.<sup>47</sup>

According to public records provided by the Department and the Board of Industrial Insurance Appeals, approximately 100 physicians have been discontinued from serving injured workers without the Department

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<sup>44</sup> CP 7; 23

<sup>45</sup> CP 7

<sup>46</sup> A-1; CP 8

<sup>47</sup> A-1; CP 8

petitioning the Board of Industrial Insurance Appeals for an order immediately suspending a provider's eligibility to participate per RCW 51.52.075.<sup>48</sup>

A large segment of the patients of both Drs. Albert and Summe are injured workers referred by other professionals.<sup>49</sup> These types of patients are harder to treat, because their conditions have proven resistant to the treatments attempted before referral.<sup>50</sup> For both Drs. Albert and Summe, terminating their ability to provide treatment for such patients deprives these injured workers of essential care.<sup>51</sup> The Department's "Urgent Action" letter,<sup>52</sup> sent directly to covered patients, states that Drs. Albert and Summe "cannot treat your workers' compensation injury."<sup>53</sup> This has resulted in on-going substantial economic loss and significant noneconomic damage to their professional reputations in their respective communities and with respect to their patients.<sup>54</sup>

### **3. Procedural Background**

On August 7, 2013, Dr. Albert and Dr. Jeff Summe filed a complaint for declaratory relief against the Department.<sup>55</sup> The complaint

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<sup>48</sup> A-1; CP 24; 42-82

<sup>49</sup> CP 6; 90

<sup>50</sup> CP 6; 90

<sup>51</sup> CP 6; 90

<sup>52</sup> A-3

<sup>53</sup> Id.

<sup>54</sup> CP 5-6; 8

<sup>55</sup> CP 3-12

alleged that the Department violated their constitutional rights by not filing petitions pursuant to RCW 51.52.075 before terminating their authority to treat injured workers.

On October 15, 2013, the trial court considered the Plaintiffs' Motion for Declaratory Relief as a dispositive motion under local rules.<sup>56</sup> The trial court denied the motion concluding that RCW 51.52.075 does not apply to denial of eligibility to participate in the Medical Provider Network.<sup>57</sup>

#### **E. STANDARD OF REVIEW**

Ordinary rules of appellate procedure apply to an appeal from a declaratory judgment.<sup>58</sup> In a declaratory judgment action, “[a]ll orders, judgments and decrees ... may be reviewed as other orders, judgments and decrees.”<sup>59</sup> According to Tegland,<sup>60</sup>

A declaratory judgment is subject to appellate review like any other final judgment.<sup>61</sup> No special procedures or standards of review apply.<sup>62</sup> Thus, findings of fact

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<sup>56</sup> LCR 5(d)(1)(D); RP 7-9

<sup>57</sup> A-10 [Findings of Fact, Conclusions of Law, and Order Denying Plaintiff's Motion for Declaratory Relief]; CP 216-218.

<sup>58</sup> *Simpson Tacoma Kraft Co. v. Department of Ecology*, 119 Wn.2d 640, 646, 835 P.2d 1030 (1992).

<sup>59</sup> *Id.* (quoting RCW 7.24.070 and *Nollette v. Christianson*, 115 Wn.2d 594, 599, 800 P.2d 359 (1990)).

<sup>60</sup> 15 L. Orland & K. Tegland, *Wash. Prac., Civil Procedure*, sec. 42.27 (2d ed.)(2013).

<sup>61</sup> RCWA 7.24.070

<sup>62</sup> *City of Spokane v. Spokane Civil Service Com'n*, 98 Wn.App. 574, 989 P.2d 1245 (Div. 3 1999) (“Ordinary rules of appellate procedure apply to an appeal from a declaratory judgment”)

supported by substantial evidence will not be disturbed on appeal, and conclusions of law are reviewed *de novo*.<sup>63</sup>

If the trial court has determined the case solely on the basis of affidavits (or declarations<sup>64</sup>), as is often done in declaratory judgment actions, all appellate review will be on a *de novo* basis. That is, both the facts and law will be reconsidered by the appellate court. Such a case is not reviewed as a summary judgment (i.e., viewing the facts in the light most favorable to the nonmoving party)<sup>65</sup> unless, of course, the case was actually resolved by the trial court on a formal motion for summary judgment.<sup>66</sup>

Here, the trial court considered the Appellants' Motion for Declaratory Relief as a dispositive motion under local rules.<sup>67</sup>

## F. ARGUMENTS

### 1. **The Department is required to follow RCW 51.52.075 before it terminates provider services to injured workers and is stayed from discontinuing provider services pending final order by the Board of Industrial Insurance Appeals.**

RCW 51.52.075<sup>68</sup> provides that:

When a provider files with the board an appeal from an order terminating the provider's authority to provide services related to the treatment of industrially injured

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<sup>63</sup> See *Nollette v. Christianson*, 115 Wn.2d 594, 800 P.2d 359 (1990).

- In a declaratory judgment action, all orders, judgments, and decrees may be reviewed as other orders, judgments and decrees, and thus, the Court of Appeals will determine if the trial court's findings of fact were supported by substantial evidence in the record: if so, the Court next decides whether those findings of fact support the trial court's conclusions of law. *Schneider v. Snyder's Foods, Inc.*, 116 Wn.App. 706, 66 P.3d 640 (Div. 3 2003).

<sup>64</sup> In most instances, an unsworn declaration may be substituted for an affidavit. CR 13.

<sup>65</sup> *Brouillet v. Cowles Pub. Co.*, 114 Wn.2d 788, 791 P.2d 526 (1990).

<sup>66</sup> If a declaratory judgment proceeding is resolved on a formal motion for summary judgment, appellate review is *de novo*, just as it is in any appeal from summary judgment. *McNabb v. Department of Corrections*, 163 Wn.2d 393, 180 P.3d 1257 (2008).

<sup>67</sup> LCR 5(d)(1)(D)

<sup>68</sup> A-1

workers, the department may petition the board for an order immediately suspending the provider's eligibility to participate as a provider of services to industrially injured workers under this title pending the final disposition of the appeal by the board. The board shall grant the petition if it determines that there is good cause to believe that workers covered under this title may suffer serious physical or mental harm if the petition is not granted. The board shall expedite the hearing of the department's petition under this section.

The clear language of RCW 51.52.075 mandates that the Department petition the board.

If language of a statute is clear, its plain meaning must be given effect without resort to rules of statutory construction. *Murphy v. Department of Licensing*, 28 Wn.App. 620, 625 P.2d 732 (1981).... When the language of a statute is clear, the courts must apply its obvious meaning. *Griffin v. Department of Social & Health Servs.*, 91 Wn.2d 616, 624, 590 P.2d 816 (1979).... The words of a statute must, absent some ambiguity or a statutory definition, be accorded their usual and ordinary meaning. *Pope & Talbot, Inc. v. Department of Rev.*, 90 Wn.2d 191, 194, 580 P.2d 262 (1978).

*State v. Theilken*, 102 Wn.2d 271, 275-76 684 P.2d 709 (1984).

Yet, the Department argued at trial that:

The old system itself was phased out, so it follows that the providers' authority to treat under it was as well. But there is no relief available by invoking RCW 51.52.075, because it is now moot. The Department need not petition the Board of an order suspending a provider's ability to treat under a system that no longer exists.<sup>69</sup>

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<sup>69</sup> CP 155 (fn. 5) [Emphasis added]

The court should interpret laws in a way that would not nullify any portion of the statute.<sup>70</sup> The legislature does not engage in unnecessary or meaningless acts, and we presume some significant purpose or objective in every legislative enactment.<sup>71</sup> As this Court stated in *Rozner v. City of Bellevue*, “The fundamental objective of statutory construction is to ascertain and carry out the intent of the Legislature.”<sup>72</sup>

The Legislature plainly intended to condition the Department’s ability to terminate a provider’s authority upon a petition to the BIIA and a finding “that there is good cause to believe that workers covered under this title may suffer serious physical or mental harm if the petition is not granted.” RCW 51.52.075. In fact, the Denial Letter states:

You are eligible reapply to the network after five (5) years, unless you were denied from network participation due to:

- ♦ Finding of risk of harm. ....<sup>73</sup>

This protocol serves the purpose of protecting constitutional interests in due process, liberty and property, as addressed *infra* at Section F.2., page 17.

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<sup>70</sup> See *Public Hosp. Dist. 2 v. Taxpayers of Pub. Hosp. Dist. 2*, 44 Wn.2d 623, 269 P.2d 594 (1954); *Group Health Coop. v. King County Medical Soc’y*, 39 Wn.2d 586, 237 P.2d 737 (1951).

<sup>71</sup> *Knowles v. Holly*, 82 Wn.2d 694, 513 P.2d 18 (1973); *Roza Irrigation Dist. v. State*, 80 Wn.2d 633, 497 P.2d 166 (1972); *Kelleher v. Ephrata School Dist.* 165, 56 Wn.2d 866, 355 P.2d 989 (1960).

<sup>72</sup> *Rozner v. City of Bellevue*, 116 Wn.2d 342, 347, 804 P.2d 24 (1991) [citing *Bellevue Fire Fighters Local 1604 v. Bellevue*, 100 Wn.2d 748, 751, 675 P.2d 592 (1984), *cert. denied*, 471 U.S. 1015 (1985)]

<sup>73</sup> A-7 [Emphasis added]

Although RCW 51.52.075 provides that the Board “shall grant the petition if it determines that there is good cause to believe that workers covered under this title may suffer serious physical or mental harm if the petition is not granted” and permits the Board to expedite the hearing on such petitions, no good cause has been attempted to be shown, has been shown, or can be shown regarding Drs. Albert and Summe.

The Department issued orders “terminating the provider’s authority to provide services related to the treatment of industrially injured workers.”<sup>74</sup> No petition to the BIIA was filed by the Department seeking immediate suspension.

Notwithstanding the fact that Drs. Albert and Summe had appealed to the Board, Dr. Albert on March 19, 2013, Dr. Summe on April 29, 2013, the Department unilaterally suspended both providers’ eligibility to participate as providers of services to industrially injured workers during the pendency of the appeal (i) without any petition to the Board for an order of immediate suspension and (ii) without any showing of “good cause to believe that workers covered under this title may suffer serious physical or mental harm if the petition is not granted.”

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<sup>74</sup> CP 28-29; 139

This is contrary to the Department's own rules and commentary.<sup>75</sup>

WAC 296-20-01100(2) states:

It is not the intent of the department to remove or otherwise take action when providers are practicing within department policies and guidelines, or within best practices established or developed by the department, or established in collaboration with its industrial insurance medical and chiropractic advisory committees.

Drs. Albert and Summe practice within those policies and guidelines.

They do not pose and were not found to pose any "risk of serious physical or mental harm" to their patients or injured workers in the State of Washington.<sup>76</sup> To the contrary, failure to allow the participation of these doctors in the provision of care to injured workers deprives such workers of competent and helpful treatment and inures to the detriment of such workers by reducing their freedom of choice between and among respected, experienced, qualified, and competent practitioners.

**2. The Department violated Article 1, section 3 of the Washington State Constitution by depriving providers of liberty and property interests without due process.**

The Washington State Constitution, Article 1, Section 3, "Personal Rights" provides: "No person shall be deprived of life, liberty, or property, without due process of law." Physicians have liberty and property

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<sup>75</sup> See, *supra* *Legislative History*.

<sup>76</sup> RCW 51.52.075 [A-1]; CP 102-105 [Dr. Albert's Declaration]; CP 106-109 [Dr. Summe's Declaration]

interests in their profession.<sup>77</sup> The “right” is due process, a doctor’s interest is his property, his liberty, or both.<sup>78</sup> As this Court noted in *Nguyen v. State, Department of Health*,

Dr. Nguyen's professional license represents a property interest to which due process protections apply. *Johnson v. Bd. of Governors*, 913 P.2d 1339 (Okla.1996) (holding a professional license is a constitutionally protected interest in property); see also *Wash. State Med. Disciplinary Bd. v. Johnston*, 99 Wash.2d 466, 474, 663 P.2d 457 (1983) (“Procedural due process imposes constraints on governmental decisions which deprive individuals of ‘liberty’ or ‘property’ interests within the meaning of the due process clauses of the fifth and fourteenth amendments to the United States Constitution.”).<sup>79</sup>

Dr. Albert cited *Nguyen* in his initial response to the Department’s Denial Letter.<sup>80</sup> In that case, this Court stated:

Our Constitution mandates that level of legal process due to reflect “respect enforced by law for that feeling of just treatment which has been evolved through centuries of Anglo-American constitutional history and civilization.” *Joint Anti-Fascist Refugee Comm. v. McGrath*, 341 U.S. 123, 162, 71 S.Ct. 624, 95 L.Ed. 817 (1951) (Frankfurter, J., concurring). “[I]n the development of our liberty insistence upon procedural regularity has been a large factor. Respect for law will not be advanced by resort, in its enforcement, to means which shock the common man's sense of decency and fair play.” *Burdeau v. McDowell*, 256 U.S. 465, 477, 41 S.Ct. 574, 65 L.Ed. 1048 (1921) (Brandeis, J., dissenting).

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<sup>77</sup> *Nguyen v. State, Dept. of Health*, 144 Wn.2d 516, 522-523, 29 P.3d 689 (2001).

<sup>78</sup> *Id.*

<sup>79</sup> *Id.*, at fn 4.

<sup>80</sup> A-7; CP 32

Representing a profound attitude of fairness between man and man, and more particularly between the individual and government, “due process” is compounded of history, reason, the past course of decisions, and stout confidence in the strength of the democratic faith which we profess.... It is a delicate process of adjustment inescapably involving the exercise of judgment by those whom the Constitution entrusted with the unfolding of the process.

*Joint Anti-Fascist Refugee Comm.*, 341 U.S. at 162-63, 71 S.Ct. 624 (Frankfurter, J., concurring).

The minimum evidentiary standard due a medical doctor in a professional disciplinary proceeding is most importantly based upon the nature of the interest at stake—the interest which is subject to erroneous deprivation if a mistake is made. The more important the interest, the less tolerant we are as a civilized society that it be erroneously deprived.

As Justice Madsen opined in *Matter of Cashaw*,<sup>81</sup>

[S]tate statutes or regulations can create due process liberty interests where none would have otherwise existed. See *Hewitt*, 459 U.S. at 469, 103 S.Ct. at 870; *Toussaint*, 801 F.2d at 1089; *Powell*, 117 Wash.2d at 202–03, 814 P.2d 635. By enacting a law that places substantive limits on official decisionmaking, the State can create an expectation that the law will be followed, and this expectation can rise to the level of a protected liberty interest. See *Toussaint*, 801 F.2d at 1094.

In that regard, RCW 51.52.075, the legislative history and implementing Network rules all “create an expectation that the law will be followed.”

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<sup>81</sup> *Matter of Cashaw*, 123 Wn.2d 138, 144, 866 P.2d 8, 11 (1994)

RCW 51.52.075 imposes minimum due process requirements limiting the Department's power to summarily terminate the provider's authority to provide services related to the treatment of industrially injured workers by conditioning it upon the granting of a petition to the Board of Industrial Insurance Appeals [BIIA]. Compliance with RCW 51.52.075 by the State is required to protect liberty and property interests of providers from deprivation without due process of law as mandated by Article 1, Section 3 of the Washington State Constitution. Unilateral actions by the Department, including notice to the National Practitioner Data Bank<sup>82</sup> and sending patients "Urgent Action Required" letters directing them to find a new provider *before* the provider's appeal period ran and *before* there is a final independent determination by the BIIA, fails to comport with traditional standards of due process and fair play and is violative of rights under Article 1, Section 3 of the Washington State Constitution.

Moreover, the Department's internal "process" fails to meet minimum constitutional requisites. In *Nguyen v. State, Department of Health*, this Court stated:

A process satisfies minimum constitutional requisites inherently due when it provides adequate safeguards to the citizen confronted by an action instigated against him by the state. Primary among these safeguards is the standard of

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<sup>82</sup> See RP 23:7-12

proof. “The function of a standard of proof ... is to ‘instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication.’ ” *Addington v. Texas*, 441 U.S. 418, 423, 99 S.Ct. 1804, 60 L.Ed.2d 323 (1979) (quoting *In re Winship*, 397 U.S. 358, 370, 90 S.Ct. 1068, 25 L.Ed.2d 368 (1970) (Harlan, J., concurring)).<sup>83</sup>

Under RCW 51.52.075 the Department has the burden to prove to a neutral body [BIIA] that a doctor is such a risk that “workers covered under this title may suffer serious physical or mental harm if the petition is not granted.” Under the new Network, however, the Department has flipped that burden and put it on the provider to prove the Department is wrong. This amounts to a rigged guessing game and is fundamentally unfair and unjust.

In *Amunrud v. Board of Appeals*,<sup>84</sup> the Court stated:

When a state seeks to deprive a person of a protected interest, procedural due process requires that an individual receive notice of the deprivation and an opportunity to be heard to guard against erroneous deprivation. *Mathews v. Eldridge*, 424 U.S. 319, 348, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976). The opportunity to be heard must be “at a meaningful time and in a meaningful manner,” appropriate to the case. *Id.* at 333, 96 S.Ct. 893 (quoting *Armstrong v. Manzo*, 380 U.S. 545, 552, 85 S.Ct. 1187, 14 L.Ed.2d 62 (1965)).

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<sup>83</sup> 144 Wn.2d 516, 524, 29 P.3d 689 (2001)

<sup>84</sup> 158 Wn.2d 208, 216, 143 P.3d 571 (2006)

Here, the Denial Letter<sup>85</sup> is the result of an internal closed-door Department review. Unlike the procedure called for by RCW 51.52.075 before the independent BIIA,<sup>86</sup> the Department's internal closed-door process does not afford the provider prior notice, a hearing,<sup>87</sup> a right to cross-examination, or any meaningful opportunity to be heard.<sup>88</sup> The Denial Letter itself does not contain any facts or allegations specific to the doctors and does not state the basis or reasons for the purported denial, and does not identify the person or persons who reviewed their applications. It appears to be a form letter which wrongly assumes they are not established providers of medical services to injured workers under the Department's policies and guidelines,<sup>89</sup> but rather are new applicants. The Denial Letter contains no reference to any of the "Minimum health care provider network standards" listed in WAC 296-20-01030. The Department has not stated that Drs. Albert or Summe fail to meet any of the minimum standards or found them to present any "risk of harm".<sup>90</sup>

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<sup>85</sup> A-7; CP 28-29

<sup>86</sup> RP 55:1-8

<sup>87</sup> RP 39:18 et seq.

<sup>88</sup> See CP 59 [at para 31]; The Department argued that "the plaintiffs were given a pre-deprivation hearing" but refers to the internal closed-door review by the credentialing committee. RP 28: 10-24.

<sup>89</sup> WAC 296-20-01100(2)

<sup>90</sup> A-7

To obtain reconsideration of the Department's decision, the Denial Letter<sup>91</sup> puts the burden on the provider who is required to:

- a. Specify the department decision(s) that is being disputed;
- b. State the basis for disputing the department decision;
- c. Include any documentation to support your request.

The Denial Letter, however, contains no factual statement of the reasons for the decision.

Moreover, the Denial Letter misstates the law. In Dr. Albert's case, the Denial Letter<sup>92</sup> states that Dr. Albert did not met:

**WAC 296-20-01050(3)(c)** The provider has a history of noncompliance with department of health or other state health care agency's stipulation to informal disposition (STID), agreed order, or similar licensed restriction.

However, that is not what WAC 296-20-01050(3)(c) says. It says:

The provider *is* noncompliant with the department of health's or other state health care agency's stipulation to informal disposition (STID), agreed order, or similar licensed restriction

The word is "*is*" not "*has been*". Statutory language must be given its usual and ordinary meaning, regardless of the policy behind the enactment.<sup>93</sup>

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<sup>91</sup> CP 28

<sup>92</sup> CP 28

<sup>93</sup> *Department of Rev. v. Hoppe*, 82 Wn.2d 549, 552, 512 P.2d 1094 (1973)

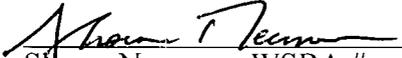
Although the Denial Letter was not the final and binding agency decision, the Department sent “**Urgent Action**” letters directly to patients *before the appeal period ran* telling them that “This provider cannot continue to treat your workers’ compensation injury.”<sup>94</sup> The Denial Letter also states that “Also, upon the effective date, the department is required to report this application denial to the National Practitioner Data Bank.” The Department reported to the National Practitioner Data Bank Drs. Albert and Summe “Failed to meet department credentialing requirements as specified in Washington Administrative Code.”<sup>95</sup>

**G. CONCLUSION**

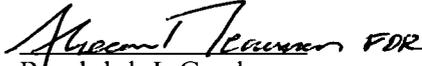
For the foregoing reasons, the trial courts order denying declaratory relief should be reversed.

Dated: January 21, 2014

**SHAWN NEWMAN**  
**ATTORNEY AT LAW, INC.**

  
Shawn Newman, WSBA #  
WSBA #14193  
Attorney for Plaintiff Albert

**LAW OFFICES OF**  
**RANDOLPH I. GORDON PLLC**

 FOR  
Randolph I. Gordon,  
WSBA# 8435  
Attorney for Plaintiff Summe

<sup>94</sup> CP 26-27 [Emphasis in original letter].

<sup>95</sup> CP 21-25; 30-31

# APPENDIX

A-1

RCW 51.52.075

§ 51.52.075. Appeal from order terminating provider's authority to provide services - Department petition for order immediately suspending provider's eligibility to participate.

## **Washington Statutes**

### **Title 51. INDUSTRIAL INSURANCE**

#### **Chapter 51.52. Appeals**

*Current through Chapter 2 of the 2013 Third Special Session*

#### **§ 51.52.075. Appeal from order terminating provider's authority to provide services - Department petition for order immediately suspending provider's eligibility to participate**

When a provider files with the board an appeal from an order terminating the provider's authority to provide services related to the treatment of industrially injured workers, the department may petition the board for an order immediately suspending the provider's eligibility to participate as a provider of services to industrially injured workers under this title pending the final disposition of the appeal by the board. The board shall grant the petition if it determines that there is good cause to believe that workers covered under this title may suffer serious physical or mental harm if the petition is not granted. The board shall expedite the hearing of the department's petition under this section.

**Cite as RCW 51.52.075**

**History.** 2004 c 259 § 1.

# **APPENDIX**

**A-2**

**RCW 51.36.010**

§ 51.36.010. Findings - Minimum standards for providers - Health care provider network - Advisory group - Best practices treatment guidelines - Extent and duration of treatment - Centers for occupational health and education - Rules - Reports.

## **Washington Statutes**

### **Title 51. INDUSTRIAL INSURANCE**

#### **Chapter 51.36. Medical aid**

*Current through Chapter 2 of the 2013 Third Special Session*

#### **§ 51.36.010. Findings - Minimum standards for providers - Health care provider network - Advisory group - Best practices treatment guidelines - Extent and duration of treatment - Centers for occupational health and education - Rules - Reports**

- (1) The legislature finds that high quality medical treatment and adherence to occupational health best practices can prevent disability and reduce loss of family income for workers, and lower labor and insurance costs for employers. Injured workers deserve high quality medical care in accordance with current health care best practices. To this end, the department shall establish minimum standards for providers who treat workers from both state fund and self-insured employers. The department shall establish a health care provider network to treat injured workers, and shall accept providers into the network who meet those minimum standards. The department shall convene an advisory group made up of representatives from or designees of the workers' compensation advisory committee and the industrial insurance medical and chiropractic advisory committees to consider and advise the department related to implementation of this section, including development of best practices treatment guidelines for providers in the network. The department shall also seek the input of various health care provider groups and associations concerning the network's implementation. Network providers must be required to follow the department's evidence-based coverage decisions and treatment guidelines, policies, and must be expected to follow other national treatment guidelines appropriate for their patient. The department, in collaboration with the advisory group, shall also establish additional best practice standards for providers to qualify for a second tier within the network, based on demonstrated use of occupational health best practices. This second tier is separate from and in addition to the centers for occupational health and education established under subsection (5) of this section.
- (2) (a) Upon the occurrence of any injury to a worker entitled to compensation under the provisions of this title, he or she shall receive proper and necessary medical and surgical services at the hands of a physician or licensed advanced registered nurse practitioner of his or her own choice, if conveniently located, except as

provided in (b) of this subsection, and proper and necessary hospital care and services during the period of his or her disability from such injury.

- (b) Once the provider network is established in the worker's geographic area, an injured worker may receive care from a nonnetwork provider only for an initial office or emergency room visit. However, the department or self-insurer may limit reimbursement to the department's standard fee for the services. The provider must comply with all applicable billing policies and must accept the department's fee schedule as payment in full.
- (c) The department, in collaboration with the advisory group, shall adopt policies for the development, credentialing, accreditation, and continued oversight of a network of health care providers approved to treat injured workers. Health care providers shall apply to the network by completing the department's provider application which shall have the force of a contract with the department to treat injured workers. The advisory group shall recommend minimum network standards for the department to approve a provider's application, to remove a provider from the network, or to require peer review such as, but not limited to:
  - (i) Current malpractice insurance coverage exceeding a dollar amount threshold, number, or seriousness of malpractice suits over a specific time frame;
  - (ii) Previous malpractice judgments or settlements that do not exceed a dollar amount threshold recommended by the advisory group, or a specific number or seriousness of malpractice suits over a specific time frame;
  - (iii) No licensing or disciplinary action in any jurisdiction or loss of treating or admitting privileges by any board, commission, agency, public or private health care payer, or hospital;
  - (iv) For some specialties such as surgeons, privileges in at least one hospital;
  - (v) Whether the provider has been credentialed by another health plan that follows national quality assurance guidelines; and
  - (vi) Alternative criteria for providers that are not credentialed by another health plan.  
The department shall develop alternative criteria for providers that are not credentialed by another health plan or as needed to address access to care concerns in certain regions.
- (d) Network provider contracts will automatically renew at the end of the contract period unless the department provides written notice of changes in contract provisions or the department or provider provides written notice of contract

termination. The industrial insurance medical advisory committee shall develop criteria for removal of a provider from the network to be presented to the department and advisory group for consideration in the development of contract terms.

- (e) In order to monitor quality of care and assure efficient management of the provider network, the department shall establish additional criteria and terms for network participation including, but not limited to, requiring compliance with administrative and billing policies.
  - (f) The advisory group shall recommend best practices standards to the department to use in determining second tier network providers. The department shall develop and implement financial and nonfinancial incentives for network providers who qualify for the second tier. The department is authorized to certify and decertify second tier providers.
- (3) The department shall work with self-insurers and the department utilization review provider to implement utilization review for the self-insured community to ensure consistent quality, cost-effective care for all injured workers and employers, and to reduce administrative burden for providers.
- (4) The department for state fund claims shall pay, in accordance with the department's fee schedule, for any alleged injury for which a worker files a claim, any initial prescription drugs provided in relation to that initial visit, without regard to whether the worker's claim for benefits is allowed. In all accepted claims, treatment shall be limited in point of duration as follows:
- In the case of permanent partial disability, not to extend beyond the date when compensation shall be awarded him or her, except when the worker returned to work before permanent partial disability award is made, in such case not to extend beyond the time when monthly allowances to him or her shall cease; in case of temporary disability not to extend beyond the time when monthly allowances to him or her shall cease:
- PROVIDED, That after any injured worker has returned to his or her work his or her medical and surgical treatment may be continued if, and so long as, such continuation is deemed necessary by the supervisor of industrial insurance to be necessary to his or her more complete recovery; in case of a permanent total disability not to extend beyond the date on which a lump sum settlement is made with him or her or he or she is placed upon the permanent pension roll: PROVIDED, HOWEVER, That the supervisor of industrial insurance, solely in his or her discretion, may authorize continued medical and surgical treatment for conditions previously accepted by the department when such medical and surgical treatment is deemed necessary by the supervisor of industrial insurance to protect such worker's life or provide for the administration of medical and therapeutic measures including payment of prescription medications, but not including those controlled substances currently scheduled by the pharmacy quality assurance commission as

Schedule I, II, III, or IV substances under chapter 69.50 RCW, which are necessary to alleviate continuing pain which results from the industrial injury. In order to authorize such continued treatment the written order of the supervisor of industrial insurance issued in advance of the continuation shall be necessary.

The supervisor of industrial insurance, the supervisor's designee, or a self-insurer, in his or her sole discretion, may authorize inoculation or other immunological treatment in cases in which a work-related activity has resulted in probable exposure of the worker to a potential infectious occupational disease. Authorization of such treatment does not bind the department or self-insurer in any adjudication of a claim by the same worker or the worker's beneficiary for an occupational disease.

- (5)
- (a) The legislature finds that the department and its business and labor partners have collaborated in establishing centers for occupational health and education to promote best practices and prevent preventable disability by focusing additional provider-based resources during the first twelve weeks following an injury. The centers for occupational health and education represent innovative accountable care systems in an early stage of development consistent with national health care reform efforts. Many Washington workers do not yet have access to these innovative health care delivery models.
  - (b) To expand evidence-based occupational health best practices, the department shall establish additional centers for occupational health and education, with the goal of extending access to at least fifty percent of injured and ill workers by December 2013 and to all injured workers by December 2015. The department shall also develop additional best practices and incentives that span the entire period of recovery, not only the first twelve weeks.
  - (c) The department shall certify and decertify centers for occupational health and education based on criteria including institutional leadership and geographic areas covered by the center for occupational health and education, occupational health leadership and education, mix of participating health care providers necessary to address the anticipated needs of injured workers, health services coordination to deliver occupational health best practices, indicators to measure the success of the center for occupational health and education, and agreement that the center's providers shall, if feasible, treat certain injured workers if referred by the department or a self-insurer.
  - (d) Health care delivery organizations may apply to the department for certification as a center for occupational health and education. These may include, but are not limited to, hospitals and affiliated clinics and providers, multispecialty clinics, health maintenance organizations, and organized systems of network physicians.
  - (e) The centers for occupational health and education shall implement benchmark

quality indicators of occupational health best practices for individual providers, developed in collaboration with the department. A center for occupational health and education shall remove individual providers who do not consistently meet these quality benchmarks.

- (f) The department shall develop and implement financial and nonfinancial incentives for center for occupational health and education providers that are based on progressive and measurable gains in occupational health best practices, and that are applicable throughout the duration of an injured or ill worker's episode of care.
  - (g) The department shall develop electronic methods of tracking evidence-based quality measures to identify and improve outcomes for injured workers at risk of developing prolonged disability. In addition, these methods must be used to provide systematic feedback to physicians regarding quality of care, to conduct appropriate objective evaluation of progress in the centers for occupational health and education, and to allow efficient coordination of services.
- (6) If a provider fails to meet the minimum network standards established in subsection (2) of this section, the department is authorized to remove the provider from the network or take other appropriate action regarding a provider's participation. The department may also require remedial steps as a condition for a provider to participate in the network. The department, with input from the advisory group, shall establish waiting periods that may be imposed before a provider who has been denied or removed from the network may reapply.
- (7) The department may permanently remove a provider from the network or take other appropriate action when the provider exhibits a pattern of conduct of low quality care that exposes patients to risk of physical or psychiatric harm or death. Patterns that qualify as risk of harm include, but are not limited to, poor health care outcomes evidenced by increased, chronic, or prolonged pain or decreased function due to treatments that have not been shown to be curative, safe, or effective or for which it has been shown that the risks of harm exceed the benefits that can be reasonably expected based on peer-reviewed opinion.
- (8) The department may not remove a health care provider from the network for an isolated instance of poor health and recovery outcomes due to treatment by the provider.
- (9) When the department terminates a provider from the network, the department or self-insurer shall assist an injured worker currently under the provider's care in identifying a new network provider or providers from whom the worker can select an attending or treating provider. In such a case, the department or self-insurer shall notify the injured worker that he or she must choose a new attending or treating provider.
- (10) The department may adopt rules related to this section.

- (11) The department shall report to the workers' compensation advisory committee and to the appropriate committees of the legislature on each December 1st, beginning in 2012 and ending in 2016, on the implementation of the provider network and expansion of the centers for occupational health and education. The reports must include a summary of actions taken, progress toward long-term goals, outcomes of key initiatives, access to care issues, results of disputes or controversies related to new provisions, and whether any changes are needed to further improve the occupational health best practices care of injured workers.

**Cite as RCW 51.36.010**

**History.** Amended by 2013 c 19, §48, eff. 7/28/2013.

Amended by 2011 c 6, §1, eff. 7/1/2011.

2007 c 134 § 1; 2004 c 65 § 11; 1986 c 58 § 6; 1977 ex.s. c 350 § 56; 1975 1st ex.s. c 234 § 1; 1971 ex.s. c 289 § 50; 1965 ex.s. c 166 § 2; 1961 c 23 § 51.36.010. Prior: 1959 c 256 § 2; prior: 1943 c 186 § 2, part; 1923 c 136 § 9, part; 1921 c 182 § 11, part; 1919 c 129 § 2, part; 1917 c 28 § 5, part; Rem. Supp. 1943 § 7714, part.

**Note:**

**Effective date -- 2011 c 6 :** "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2011." [ 2011 c 6 §2.]

**Report to legislature -- 2007 c 134:** "By December 1, 2009, the department of labor and industries must report to the senate labor, commerce, research and development committee and the house of representatives commerce and labor committee, or successor committees, on the implementation of this act." [2007 c 134 § 2.]

**Effective date -- 2007 c 134:** "This act takes effect January 1, 2008." [2007 c 134 § 3.]

**Report to legislature -- Effective date -- Severability -- 2004 c 65:** See notes following RCW 51.04.030.

**Effective dates -- Severability -- 1971 ex.s. c 289:** See RCW 51.98.060 and 51.98.070.

# APPENDIX

## A-3

Department's "Urgent  
Action Required"  
letter to patients

Day 34  
letter



STATE OF WASHINGTON  
DEPARTMENT OF LABOR AND INDUSTRIES  
*Tunwater Building, PO Box 44261, Olympia, WA 98504-4261*

Claim # (Claim Number)  
Claimant Last, First Name

## Urgent Action Required

Date

Claimant First Last Name  
Claimant/Legal Rep Address line 1  
Claimant/Legal Rep Address line 2  
Claimant/Legal Rep City, State Zip

Dear Claimant First Last Name:

Your current provider, (Provider first, last name, Credential), is not enrolled in Labor & Industries' new Medical Provider Network. This provider cannot continue to treat your workers' compensation injury.

If you need additional treatment for your workers' compensation injury, you must transfer your care to a network provider. Failure to transfer to a network provider within 30 days could disrupt benefits such as time-loss compensation and medical services.

To find and transfer to a network provider:

1. Find network providers in your area using [www.FindADoc.Lni.wa.gov](http://www.FindADoc.Lni.wa.gov).
2. Contact new providers to make sure they will accept you as a patient, and make an appointment.

Once you have an appointment with a provider who has agreed to treat you, request a transfer to the new provider at [www.TransferCare.Lni.wa.gov](http://www.TransferCare.Lni.wa.gov).

If you need help, call 1-800-547-8367 or your local L&I office.

Go to [www.NetworkInfo.Lni.wa.gov](http://www.NetworkInfo.Lni.wa.gov) for answers to frequently-asked questions about L&I's Medical Provider Network.

Please contact your provider if you have questions about why your current provider is not in the network.

Cc: Claim file  
Provider

*Affirmed  
Denial  
letter*



STATE OF WASHINGTON  
DEPARTMENT OF LABOR AND INDUSTRIES  
*Tumwater Building, PO Box 44261, Olympia, WA 98504-4261*

Claim #(Claim Number)  
(Claimant Last Name), (Claimant First Name)

## Urgent Action Required

Date

Claimant Name  
Claimant Address  
Claimant City, St Zip

Dear Claimant Name:

Your current provider, (Provider Name), is not enrolled in Labor & Industries' new Medical Provider Network. This provider cannot continue to treat your workers' compensation injury, effective (Date).

If you need additional treatment for your workers' compensation injury, you must transfer your care to a network provider. Failure to transfer to a network provider within 30 days could disrupt benefits such as time-loss compensation and medical services.

To find and transfer to a network provider:

1. Find network providers in your area using [www.FindADoc.Lni.wa.gov](http://www.FindADoc.Lni.wa.gov).
2. Contact new providers to make sure they will accept you as a patient, and make an appointment.

Once you have an appointment with a provider who has agreed to treat you, request a transfer to the new provider at [www.TransferCare.Lni.wa.gov](http://www.TransferCare.Lni.wa.gov).

**If you need help, call 1-800-547-8367 or your local L&I office.**

Go to [www.NetworkInfo.Lni.wa.gov](http://www.NetworkInfo.Lni.wa.gov) for answers to frequently-asked questions about L&I's Medical Provider Network.

Please contact your provider if you have questions about why your current provider is not in the network.

Cc: Claim file  
Provider

# APPENDIX

A-4

Washington Final Bill  
Report, 2004 Reg.  
Sess. S.B. 6428, for  
what became  
RCW 51.52.075

**FINAL BILL REPORT**

**SSB 6428**

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**C 259 L 04**

Synopsis as Enacted

**Brief Description:** Concerning industrial insurance health care providers.

**Sponsors:** Senate Committee on Commerce & Trade (originally sponsored by Senator Honeyford).

**Senate Committee on Commerce & Trade**

**House Committee on Commerce & Labor**

**Background:** If the Department of Labor and Industries (L&I) suspends a provider's eligibility to provide services to industrially injured workers and the provider appeals the suspension order to the Board of Industrial Insurance Appeals (BIIA), L&I's suspension order is stayed pending the outcome of the appeal. As a result of the stay, the provider can continue to provide workers' compensation health services.

**Summary:** If a provider of services related to the treatment of industrially injured workers appeals to the BIIA an order issued by L&I suspending the provider's authority to provide services, L&I may petition the BIIA for an order immediately suspending the provider's eligibility to participate as a provider of services in workers' compensation cases. The BIIA must grant the petition if there is good cause to believe the workers subject to the workers' compensation laws may suffer serious physical or mental harm if the suspension is not granted. BIIA must expedite the hearing of L&I's petition.

**Votes on Final Passage:**

Senate 27 21

House 96 0 (House amended)

Senate 49 0 (Senate concurred)

**Effective:** June 10, 2004

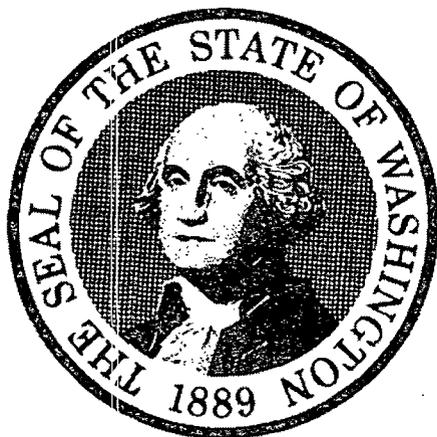
# APPENDIX

A-5

RCW 51.52.075,  
2004 Wash. Laws c  
259 § 1  
(eff. June 10, 2004)

**2004**  
**SESSION LAWS**  
OF THE  
**STATE OF WASHINGTON**

REGULAR SESSION  
FIFTY-EIGHTH LEGISLATURE  
Convened January 12, 2004. Adjourned March 11, 2004



Published at Olympia by the Statute Law Committee under  
Chapter 6, Laws of 1969.

DENNIS W. COOPER  
Code Reviser

<http://slc.leg.wa.gov>

(3) To encourage employment of injured workers who are not reemployed by the employer at the time of injury, the department may adopt rules providing for the reduction or elimination of premiums or assessments from subsequent employers of such workers and may also adopt rules for the reduction or elimination of charges against such employers in the event of further injury to such workers in their employ.

(4) To encourage employment of injured workers who have a developmental disability as defined in RCW 71A.10.020, the department may adopt rules providing for the reduction or elimination of premiums or assessments from employers of such workers and may also adopt rules for the reduction or elimination of charges against their employers in the event of further injury to such workers in their employ.

Passed by the Senate February 16, 2004.

Passed by the House March 3, 2004.

Approved by the Governor March 31, 2004.

Filed in Office of Secretary of State March 31, 2004.

### CHAPTER 259

[Substitute Senate Bill 6428]

#### DEPARTMENT OF LABOR AND INDUSTRIES—HEALTH CARE PROVIDERS

AN ACT Relating to the role of the department of labor and industries in regards to health care providers; and adding a new section to chapter 51.52 RCW.

Be it enacted by the Legislature of the State of Washington:

NEW SECTION. Sec. 1. A new section is added to chapter 51.52 RCW to read as follows:

When a provider files with the board an appeal from an order terminating the provider's authority to provide services related to the treatment of industrially injured workers, the department may petition the board for an order immediately suspending the provider's eligibility to participate as a provider of services to industrially injured workers under this title pending the final disposition of the appeal by the board. The board shall grant the petition if it determines that there is good cause to believe that workers covered under this title may suffer serious physical or mental harm if the petition is not granted. The board shall expedite the hearing of the department's petition under this section.

Passed by the Senate March 8, 2004.

Passed by the House March 3, 2004.

Approved by the Governor March 31, 2004.

Filed in Office of Secretary of State March 31, 2004.

### CHAPTER 260

[Engrossed Substitute Senate Bill 6112]

#### SELF-FUNDED MULTIPLE EMPLOYER ARRANGEMENTS

AN ACT Relating to self-funded multiple employer welfare arrangements, amending RCW 48.02.190, 48.03.060, 48.14.0201, 48.41.030, and 48.41.060; adding a new section to chapter 48.43 RCW; adding a new section to chapter 48.31 RCW; adding a new section to chapter 48.99 RCW; adding a new chapter to Title 48 RCW; prescribing penalties; and declaring an emergency.

# APPENDIX

## A-6

### Concise Explanatory Statement (CES) for WAC 296-20-01010 to 01100

## Concise Explanatory Statement (CES)

The purpose of this rulemaking is to establish a new statewide medical provider network. This rulemaking includes the following new WAC sections.

### NEW SECTIONS

WAC 296-20-01010	Scope of Health Care Provider Network
WAC 296-20-01020	Health Care Provider Network Enrollment
WAC 296-20-01030	Minimum Health Care Provider Network Standards
WAC 296-20-01040	Health Care Provider Network Continuing Requirements
WAC 296-20-01050	Health Care Provider Network Further Review and Denial
WAC 296-20-01060	Delegation of Credentialing and Recredentialing Activities
WAC 296-20-01070	Waiting Periods for Reapplying to the Network
WAC 296-20-01080	Management of the Provider Network
WAC 296-20-01090	Request for Reconsideration of Department Decision
WAC 296-20-01100	Risk of Harm

#### I. *Reasons for adopting the rule change:*

Substitute Senate Bill 5801 (SSB 5801, Chapter 6, Laws of 2011) amends RCW 51.36.010 and directs the Department of Labor & Industries (Department or L&I) to establish a medical provider network for injured workers of both state fund and self-insured employers and to expand Centers of Occupational Health and Education (COHEs). Rules are necessary to implement the changes. The Department will create and/or amend necessary rules in phases. The initial set of rules is needed for the establishment of the medical provider network.

These rule changes are expected to improve quality of medical services provided to injured and ill workers and reduce long-term disability and associated costs. These new rules enable the Department to establish an open medical network, using common standards for medical providers, while still allowing injured workers to choose their provider. The changes will help return more workers to good health and get them back on the job after an injury.

Additionally, statute requires L&I to seek the input of the Industrial Insurance Medical Advisory Committee (IIMAC) and to form a Provider Network Advisory Group (PNAG). The PNAG includes representatives from business, labor, IIMAC, and the Industrial Insurance Chiropractic Advisory Committee (IICAC).

The Department has developed these rules with the assistance of the PNAG and IIMAC. A subcommittee of IIMAC drafted the risk of harm language, and the full IIMAC, in a public meeting with public comment, refined and approved the language. The PNAG assisted in the development of minimum provider credentialing standards over two public meetings, which included public comments, and provided detailed feedback in one meeting on the overall rules.

**The intended date of adoption for this rule is January 3, 2012**

**The intended effective date for this rule is February 3, 2012.**

**II. Purpose of the concise explanatory statement:**

The purpose of this document is to respond to the oral and written comments, directly related to the proposed rule language, received through the public comment period and public hearings. The public comment period for this rulemaking began November 1, 2011, and ended December 16, 2011.

**III. Public hearings:**

Three public hearings were held to receive comments from interested parties regarding this rulemaking. The hearings took place on December 8<sup>th</sup> at SeaTac Airport, December 12<sup>th</sup> in Tumwater, and December 16<sup>th</sup> in Spokane; two hearings were held during business hours and one was held in the evening. Each hearing had about ten attendees; three people testified at the first hearing, four testified at the second hearing, and none at the third hearing.

Total Attendance: 31 individuals attended the hearings

- Signed in supporting the proposed rule: 9
- Signed in opposing the proposed rule: 6
- Signed in supporting the proposed rule with minor changes: 9

**IV. Summary of comments received directly related to this rulemaking, including Department responses and, where applicable, changes to the rules:**

The Department received 39 written comments from provider associations, individual providers, attorneys, a medical device manufacturer, and a labor representative. About 15 submissions, most from organizations, contained detailed comments on sections of the rule, which are responded to in the corresponding section. Six commenters expressed support for the rule, while 20 opposed.

## Overall Rule Comments

### Comments:

The Department received oral and written comments supporting the rule, with representative comments below.

*Creating a Medical Provider Network and expanding the Centers for Occupational Health Education supports our shared goal of injured workers' receiving the best possible care from the beginning of their claims. Access to qualified care providers is a key to meeting this goal. As we build and shape the Medical Provider Network and COHE Expansion, we aim to strike the right balance of rigor around the quality of care without being so restrictive that we exclude quality providers or discourage good providers from applying.*

*The Provider Network Advisory Group worked to define and outline the important elements necessary to ensure the success of the new provide network. These efforts were developed over six months of consideration. We reviewed and gave consideration to all issues related to these important steps. A consensus was arrived at in proposing what is before you today.*

*After an initial review, I support the proposal as written. We deal with many claims where the providers that are managing those claims do not use sound objective-based medicine to determine whether or not to accept or extend a claim. And I think that anything that can strengthen the network of providers and ensure that they are credentialed to use objective-based medicine to make those determinations would be an improvement and eventually save the state and employers a great deal of money as well as time.*

The Department also received oral and written comments opposing the rule; with representative comments below.

*I think that will make it more difficult for injured workers to find treating physicians, and obviously it will limit their choice of doctors that they can choose to treat them. And I think these things are in violation of other aspects of Title 51 and the industrial insurance laws and intent. The L&I system has become increasingly cumbersome and difficult to provide the care that is needed. Any new regulations that decrease due process would be very problematic.*

*I am quite concerned that if the rules pass as they are written, we are doing a disservice to injured workers throughout the state of Washington, to the medical providers who offer the needed care, and ultimately to the Department of Labor and Industries. If the proposed rules become final, workers will see a vast decrease in the number of medical providers and medical care will suffer. All in all, the entire rule seems to go way beyond what is needed to set up a network of licensed and competent providers of all types.*

*I am opposed to the new medical network. This takes away the patients right to the provider of their choice; it takes away providers ability to treat injured workers and reduces the quality of care to injured workers. If injured workers are unable to get quality care they will be out of*

*work longer and finally return with greater disabilities than before. This is bad for industry and workers.*

*I have grave concerns about L&I, but particularly with self insurers putting together their own provider panels. This network will only cause more issues because the end result is L&I will pick who they want as a doctor to do their bidding or you will not be included. In other words those that will say the injured worker's condition is fixed and stable forcing the injured worker to appeal every denial for treatment.*

*Please do not allow this WAC to pass. As written it is without due process and allows one person to choose the worker's attending physician.*

*We believe that doctors should not be automatically terminated from the network for treatment or procedures that are outside the guidelines. We are concerned that individual clinical circumstances and decisions will not be considered in the guideline development and implementation process. The Department rules and guidelines must be more flexible to allow treatment where strictly following Department guidelines is a potential risk of harm to the patient.*

**Response:** The Department agrees that a medical provider network is required by the worker's compensation reform law passed in 2011 and that it supports the goal of injured workers' receiving the best possible care through access to qualified care providers. The draft rules were carefully crafted by Department staff and the newly formed Provider Network Advisory Group that is composed of four physicians, two chiropractors, two business representatives, and two labor representatives. Over the course of six months of discussion, including four public meetings, the advisory group drafted, revised, and finally approved the rules through a consensus process.

The main reasons expressed for opposing the rule include the following four themes, addressed below: decreased access, closed or limited network, self-insured standards, and appeal rights.

1) It will decrease access

The Department is committed to broad access and recruitment and has proposed an open network with transparent minimum standards. Workers will have their choice of a provider in the network for ongoing care and the network rules include an exception in case adequate coverage within a geographic area is not maintained by the planned January 1, 2013, start date. The Department based the network requirements on common criteria among private and public payers; and further refined them by ensuring they had full support from the advisory group, particularly unanimous support from the six provider representatives. This resulted in generally more favorable criteria to providers, but the Department believes the criteria will ensure and promote quality.

2) The network is limited or inclusion is based on selection by medical director

The network is open to all providers. The Department encourages all providers to apply. As further described in the subsections below, the Department will approve any provider meeting the minimum standards and continuing requirements. The Department is using an

industry standard and a National Committee for Quality Assurance (NCQA) recommended process to make the enrollment decisions. To ensure the input of a senior clinician, the Medical Director has the final review of these important decisions to ensure they are made following the criteria established in the rule and policy. As noted in the rule, applications requiring further review will also include recommendations of other clinicians based on peer or clinical review; a credentialing committee, or the industrial insurance medical or chiropractic advisory committees.

3) Self-insured employers are not subject to the same standard

Self-insured employers are subject to the same rule. Both the statute creating the medical provider network and the network rules require that the standards apply to workers covered by either the Washington state fund or self-insured employers.

4) Providers can't appeal a decision

There are several opportunities for appeal or review of a decision. The rule includes a process for a provider to request reconsideration of a decision using timelines that are common for review of most Department decisions. The appeal rights that apply to any Department action remain in effect and contain the process for further appeal. These rules do not limit this process. Clarifying language has been added to be explicit that the current appeal process applies.

**Rule Change:** The Department intends to adopt the medical provider network rules, with clarifying changes as specified, by section, below.

**WAC 296-20-01010 Scope of Health Care Provider Network**

The Department received oral and written comments related to the scope of the provider network, summarized below.

**Comments:**

- a. *This implementation date in the Rule exceeds the authority of the statute by imposing a drop dead implementation date.*
- b. *The Rule should specify that health care providers of a type not listed in this subsection may still treat injured workers under existing Rules.*
- c. *There isn't a reference to psychologists in the listing of providers in the network. I'm concerned that it is not listed in the initial phase.*
- d. *Disagree with ER physicians' exclusion and ability for them to continue to get paid for follow-up care; and there is a substantial fiscal incentive for ER providers to maintain volume by having worker's comp patients follow up care, but ER providers generally have little training in occupational medicine.*
- e. *Change ER Physician to ER Provider.*
- f. *Must all doctors performing IME's be in the network to continue to perform IME's?*

**Response:**

- a. The Department disagrees that specifying an implementation date exceeds the authority granted by SSB 5801 to implement a health care provider network. The implementation date is needed for the Department to provide notice on when the network will formally begin and delineate when the requirements will apply.
- b. We agree, the rule does specify at (3) and (4) that providers not listed may still be reimbursed for treatment beyond the initial visit.
- c. The Department is phasing in the rules, starting with those listed as attending providers, and psychologists are not attending providers. Under (4), L&I will phase in standards for other provider types. Until they are invited to join the network, other provider types can continue to treat injured workers without joining.
- d. The Department shares the concern that some providers will not be subject to the same standards, but needs to phase implementation in. The network advisory group discussed adding limitations on the ER exclusion, but could not identify a limitation that would be viable and not unduly restrict emergent care. The Department will monitor this issue.
- e. Agreed, the exclusion should be for emergency room providers, not solely ER physicians.
- f. The first phase of network standards applies only to attending providers that are providing ongoing treatment, including: physicians, chiropractors, naturopathic physicians, doctors of podiatry, advanced registered nurse practitioners, physician assistants, dentists, and optometrists. L&I will phase in standards for other provider types. An IME doctor would need to apply to the network if they are also providing ongoing treatment as one of the provider types listed above.

**Rule Change:** The Department made six clarifying changes to this section: five minor wording changes to ensure consistency in terms throughout the rule, and one to clarify the exception for ER providers.

**WAC 296-20-01020 Health Care Provider Network Enrollment**

The Department received oral and written comments related to the health care provider network enrollment, summarized below.

**Comments:**

- a. *Several commenters requested the Department include a deadline by which applications will be processed by the Department. Based on a sense that this provides fairness and balance because health care providers are required to meet deadlines. Alternatively, a commenter requested adding "within a reasonable time".*
- b. *Opposed to the rule because providers must have a DEA registration to be included in the network, and not all providers prescribe.*

- c. *Current language refers to the "The Department" will not pay or may pay, but there is no language about self-insurers.*
- d. *The Department, not the Department's medical director or designee should be authorized to deny or approve applications.*
- e. *Opposed to the requirement for attestation; and provisional enrollment was too vague.*
- f. *Requested the Department pay for care prior to application approval; bills from non-network doctors will not be paid after initial visit, but concern expressed if the injured worker is non-English speaking and doesn't know the laws, or doctor doesn't know the new insurance rules and provides treatment, and it is not lawful to bill client.*

**Response:**

- a. The Department's goal is to ensure a robust provider network with timely processing and agrees that including "within a reasonable time" is important. The Department disagrees with comments requesting 30 day timeframes. The current industry standards and NCQA requirements for processing provider applications range from 90 to 120 days; and NCQA requires notification within 60 days after a credentialing committee decision is reached (not after receipt).
- b. The Department agrees that not all providers need to have a DEA registration and the current rule requires a current DEA registration only if applicable to the provider's scope of practice.
- c. The Department agrees that the medical provider network rules regarding payment to only network providers should apply to both self-insurers and the Department.
- d. The Department believes designating the individual within the organization responsible for approving or denying applications, consistent with these rules, improves accountability and transparency, as well as demonstrates consistency with industry best practice. The law and rules specify that the Department will approve any provider meeting the minimum standards and continuing requirements. The Department is using an industry standard and a National Committee for Quality Assurance (NCQA) recommended process to make enrollment decisions. To ensure the input of a senior clinician, the medical director has the final review of these important decisions to ensure they are made following the criteria established in rule and policy. As noted in the rule, applications requiring further review will also include recommendations of other clinicians based on peer or clinical review; a credentialing committee, or the industrial insurance medical or chiropractic advisory committees. The Department disagrees that attestation provisions be removed because standard provider applications require them. The Department disagrees that additional rules are required to describe provisional enrollment, procedural steps and instructions will be included in implementation.
- e. The Department disagrees with the request to pay for care prior to an approved application. Paying only network providers is fundamental to the network establishment and goals of ensuring quality care by approved providers. Provisional enrollment and the ability to pay for an initial visit are included to assure timely access for urgent care and first visits, plus ongoing treatment if a provider is not currently in the network.

**Rule Change:** The Department made four clarifying changes to this section: one editorial correction, one correction to clarify the Department's response time, and two changes to clarify application to both the Department and self-insurers.

**WAC 296-20-01030 Minimum Health Care Provider Network Standards**

The Department received oral and written comments related to the health care provider network standards, summarized below.

**Comments:**

- a. *Some commenters disagreed with all minimum standards, indicating that no doctors will pass the standards because a doctor has to be perfect, literally perfect without ever a complaint, malpractice claim, investigation (formal or informal); or that they were too broad.*
- b. *Some commenters agreed with the requirement to sign the provider contract without modification for reasons of standardization; some requested to review the contract before finalization; and some commenters opposed the requirement to sign without modification.*
- c. *Some commenters agreed that language allowing flexibility as professional liability standards and economic circumstances change; while other commenters disagreed that there should be amounts specified or that amounts specified by the Department left an unreasonable degree of authority to the Department in determination of the adequacy of professional liability coverage and may be applied differentially to individual providers.*
- d. *One commenter objected to the minimum standard related to limitation of clinical admitting and management privileges.*
- e. *Several commenters expressed concern that physicians who have been terminated for convenience from public program such as Medicaid or other program would not meet the minimum health care provider network standards, and would therefore be excluded, but these terminations are not for quality of care or cause issues and they may have no appeal rights.*
- f. *Some commenters questioned "material misstatement or omission" as not being defined, or requested that it include intent.*
- g. *One commenter objected to the minimum standard related to felony convictions as overly broad and requested it be limited to crimes that could impact care and management of patients, while another requested a time limit.*
- h. *One commenter objected to the minimum standard related to licenses being free of restrictions, limitations, or conditions as too broad.*

**Response:**

- a. *The Department disagrees that the minimum standards proposed are overly difficult or that no doctors will pass the standards. Most of the minimum standards are based on the statutory provisions which commercial and other public payers currently require*

either equivalent or higher standards. The Provider Network Advisory Group carefully considered each minimum standard and all members unanimously supported the proposed standards.

- b. The Department agrees that current industry practice and a need for standardization require signing a contract without modification. The Department will make the agreement available to interested stakeholders prior to finalizing, but disagrees that individual change and negotiation is appropriate.
- c. Specifying an amount of malpractice insurance is one of the statutory requirements and an industry standard. The ability for the Department to adjust was suggested by the network advisory group to ensure that for certain provider types, a different amount (potentially lower) would be more appropriate, especially where future network phases include ancillary providers. The Department does not intend that the amounts specified would be applied individually and agrees that providing an opportunity to comment prior to any additional specification is appropriate.
- d. The Department disagrees that this is overly burdensome and agrees with the Provider Network Advisory Group recommendation.
- e. Several commenters expressed concern that physicians who have been terminated for convenience from a public program such as Medicaid or other programs would not meet the minimum health care provider network standards, and would therefore be excluded, but these terminations are not for quality of care or cause issues and they may have no appeal rights. ✓
- f. The Department agrees that a technical oversight or omission should not be grounds for denial and included "material" before "misstatement or omission". The Department disagrees that intent must be demonstrated if the misstatement is material. The Provider Network Advisory Group also discussed this issue and recommended the proposed language based on consistency with industry standard and the difficulty in proving intent. ✓
- g. The minimum qualification related to criminal history is limited to felony convictions and includes an exception if the applicant has the record expunged. The Provider Network Advisory Group considered felonies, gross misdemeanors, and all crimes related to health care and unanimously agreed that the appropriate level for a minimum standard was a felony. The Department agrees with this decision.
- h. The Department disagrees that a minimum standard related to licenses being free of restrictions, limitations, or conditions is too broad. The standard is based on the statutory requirement and consistent with public and commercial payers as well as the network goal of ensuring providers deliver quality care.

**Rule Change:** The Department made seven clarifying changes to this section: two changes to make terms consistent, one editorial correction, two corrections to clarify the Department's intent to provide opportunity for comment, and two changes to clarify that termination is based on cause.

**WAC 296-20-01040 Health Care Provider Network Continuing Requirements**

The Department received oral and written comments related to the health care provider network continuing requirements, summarized below.

**Comments:**

- a. *Subsection (2) does not make sense when parsed out – i.e. "Provide services according to ... billing instructions. Other commenters requested adding BIIA and Court orders, and medical director coverage decisions if that is not covered by rules and policies.*
- b. *Subsection (3) "material compliance" is not defined. Several commenters disagreed with the requirement to maintain compliance with the Department's evidence based coverage decision and treatment guidelines, because they believe they are controversial, not applicable to individual patients and clinical scenarios, or would require a provider to choose between providing care they believe is appropriate and risk network removal. Others requested additional language similar to language in the statute or clarifying the role that individual patient variation and clinical judgment play. One commenter indicated that they were anticipating that there would be something about following best practices guidelines or something alluding to best occupational medicine guidelines and encouraged language related to it. One commenter suggested that Department standards, decisions, policies and guidelines be kept up-to date and in an easily accessible fashion, such as a handbook on a provider page.*
- c. *Several commenters requested more time for notification of changes to L&I, generally 30 days.*

**Response:**

- a. The Department agrees that an editorial change is necessary for subsection (2).
- b. The Department and Provider Network Advisory Group spent significant time discussing on requirements contained in subsection (3) and the next section for compliance with Department standards, coverage decisions, and treatment guidelines. The statute that the Department is implementing addresses this directly: "Network providers must be required to follow the Department's evidence-based coverage decisions and treatment guidelines, policies and must be expected to follow other national treatment guidelines appropriate for their patient." We agree with the statutory requirement, the provider network advisory group, and comments that a core component of the network's ability to increase quality care is to ensure Department policy and rules, as well as treatment guidelines are followed. We agree that mirroring the statutory language is best to ensure consistency with this legal requirement and addresses the concern that a guideline needs to be appropriate for the patient. The Department will continue to publish guidelines on its website and notify providers affected through list-serves and other mechanisms, including working with provider associations to distribute notice of updates or important changes. The Department is open to additional suggestions on

how best to ensure ongoing communication and network implementation strategies to assure workers receive appropriate high quality care.

- c. The Department disagrees that two weeks is insufficient if providers have major changes that could impact their ability to practice or their patients' ability to seek care or communicate with them. A survey of public and private payer requirements ranged from a notification period of "immediate", to 3 days, 7 days, and 10 days. The Department originally proposed 7 days, but agreed to change to 14 days based on discussion and request from the provider network advisory group.

**Rule Change:** The Department made two clarifying changes to this section: one editorial correction, and one correction to ensure consistency with the statute about applicability of treatment guidelines.

**WAC 296-20-01050 Health Care Provider Network Further Review and Denial**

The Department received oral and written comments related to the health care provider network review and denial section, summarized below.

**Comments:**

- a. *Subsection (1) includes 'credentialing information obtained from other sources'. Several commenters requested limiting the Department review to confirming what is in the providers application or getting the provider's permission to contact other sources.*
- b. *Subsection (2) gives authority specifically to the medical director or designee. Several commenters object because it is too much power for one individual or on the basis that it gives the medical director authority to choose only those providers he/she likes. This will eliminate ability of workers to trust the doctors and will close the system to many. Objective verifiable renewable standards must be established to avoid arbitrary and capricious elimination of attending physicians.*
- c. *Subsection (3) – This subsection lists the reasons the dept. may deny a provider application. Some commenters agreed that there can and should be such a list according to the statute while others disagreed with one or more criteria. Some commenters felt that the 'including, but not limited to' language was too broad and left open the possibility that denial could be for no reason.*
- d. *Nowhere in this list of minimum standards is the requirement that the provider be credentialed by another health plan which uses NCQA or similar guidelines. This was intended to be the primary requirement for participation in the provider network. Instead, these rules propose setting up an extensive and separate application and credentialing process. This provides broader authority to the Office of the Medical Director than the stakeholders agreed to, and promises to severely limit the pool of providers willing to treat injured workers.*

*Remaining comments are specific to each review criteria*

- e. *Subsection (3)(c)/(d) Doctors with orders issued against them cannot be part of the network, or can be removed or suspended it seems, but what if the Department's allegations and corresponding Order are incorrect and false. Additionally, any pending statement of charges or notice of proposed disciplinary action should be limited to final actions.*
- f. *Subsection (3)(e)/(f) – Some commenters objected to any termination being reviewed and others requested including terminations for convenience while others requested; some commenters wanted fewer terms or clarification or terms such as expelled, excluded or terminated. Additionally commenters noted that commercial plans may terminate for business reasons, this could allow a provider's application to be denied if he or she was terminated from an insurance plan without cause. Some commenters were concerned that commercial plans may terminate for business reasons, this could allow a provider's application to be denied if he or she was terminated from an insurance plan without cause.*
- g. *Subsection (g) This section should be revised to eliminate the terms "while under investigation for." If allegations were unfounded, a provider's application should not be denied. An alternative approach would be to suspend the review of the application and suspend the 60 day time period until the investigation is completed.*
- h. *Subsection (3)(h) Some commenters objected to the alternative of an inpatient coverage plan in place acceptable to the Department.*
- i. *Subsection (3)(i) includes "significant malpractice claims" – while it does say based on severity, recency, frequency, or repetition, rules are provided to define terms and put parameters around the assessments. These terms are not defined, and no explanation is provided as to how they will be viewed.*
- j. *Subsection (3)(j) There is a concern around treatment flexibility related to following treatment guidelines. The Department's treatment guidelines are intended to be guidelines and there is a concern that doctors should not be automatically terminated from the network for treatment or procedures that are outside the guidelines. Another commenter proposed inserting language to the effect that where the BIA, or any court, has ordered the worker receive proper and necessary treatment, it shall not disqualify providers.*
- k. *Subsection (3)(k)(i) There was a concern that the criteria related to negligence, incompetence, inadequate or inappropriate treatment or lack of appropriate follow up was too broad; another comment that it was repetitive of malpractice claims; another comment to add "serious" before injury to worker, and a concern about due process.*
- l. *Subsection (3)(m) – should require 'knowingly' using an unlicensed provider.*
- m. *Subsection (3)(n) concern about the criteria related to a provider with a history of alcohol or chemical dependency; requiring furnishing of documentation; or requiring compliance with any treatment; and what private limitations means.*
- n. *Subsection (3)(o) What is an informal licensure action, condition or agreement? Should these always disqualify a provider from the network? Are they likely to be administrative and not related to patient care?*

- o. Subsection (3)(q) the language, 'or has a history of other significant billing irregularities' is too vague and broad. There should be some administrative or court finding that the provider has engaged in billing fraud or abuse.
- p. Subsection (3)(r) Concern that the subsection on complaints is too vague.
- q. Subsection (3)(s) Concern that a provider can be denied for any criminal history, is overly broad.

**Response:**

- a. The Department needs to be able to ensure that applications are complete and will use standard credentialing processes, which includes information obtained from other organizations, or public entities. The Department will ensure that providers have an opportunity to supplement or explain any information prior to a final decision.
- b. The Department believes designating the individual within the organization responsible for approving or denying applications, consistent with these rules, improves accountability and transparency, as well as demonstrates consistency with industry best practice. The law and rules specify that the Department, through the medical director, will approve any provider meeting the minimum standards and continuing requirements. The Department is using an industry standard and a National Committee for Quality Assurance (NCQA) recommended process to make enrollment decisions. To ensure the input of a senior clinician, the Medical Director has the final review of these important decisions to ensure they are made following the criteria established in rule and policy. As noted in the rule, applications requiring further review will also include recommendations of other clinicians based on peer or clinical review, a credentialing committee, or the industrial insurance medical or chiropractic advisory committees.
- c. The Department agrees with commenters, the statute, and the Provider Network Advisory Group that listing the criteria that trigger additional review is important for transparency and effective maintenance of the network. The Department emphasizes that these will trigger a review and can be considered by the Department, but would not automatically or necessarily require denial. The Department agrees that the language "but not limited to" may leave the criteria overly broad.
- d. The Department agrees that credentialing by another entity is encouraged and provides evidence of current compliance with some standards, and will make the provider application process more streamlined, but disagrees that this is required for enrollment in the provider network.

*Responses to specific review criteria*

- e. Subsection (3)(c)/(d) The review criteria do not equal an automatic denial. The language in (c) indicates that the Department can review clinicians who are non-compliant with disciplinary or license restrictions; additionally the Department would review and pending statement of charges. For providers with pending allegations the Department determines are serious enough to warrant denial, a provider may re-apply after the pending charges are resolved.

- f. Subsection (3)(e)/(f) – The Department agrees with the current industry standards as well as Provider Network Advisory Group that termination, expulsion, and exclusion are important criteria that would trigger further review. The terms are not further defined because different entities use different terms. The Department further agrees that a provider would not be denied enrollment solely on the basis of a termination that was related to a business management reason of a plan or other organization, and has included an exception for that.
- g. The Department agrees that if allegations under investigation are resolved, the provider should be permitted to re-apply and the Department has included an exception to the waiting period for re-application period.
- h. The Department agrees with the Provider Network Advisory Group who recommended additional flexibility to the requirement for clinical admitting and management principles. The Department included an alternative option if a provider does not have clinical admitting privileges; and disagrees with comments that the alternative coverage plan should not be reviewed and found acceptable by the Department.
- i. The Department agrees that malpractice claims are an important criterion to trigger review and agrees with the Provider Network Advisory Group recommended language that ensures that not every claim would be a reason for denial and further defines significance with the factors the Department will consider.
- j. The Department and Provider Network Advisory Group spent significant time discussing requirements contained in subsection (3) and the next section for compliance with Department standards, coverage decisions, and treatment guidelines. The statute that the Department is implementing addresses this directly: "Network providers must be required to follow the Department's evidence-based coverage decisions and treatment guidelines, policies and must be expected to follow other national treatment guidelines appropriate for their patient." We agree with the statutory requirement, the provider network advisory group, and comments that a core component of the network's ability to increase quality care is to ensure Department policy and rules, as well as treatment guidelines are followed. We agree that mirroring the statutory language is best to ensure consistency with this legal requirement and addresses the concern that a guideline needs to be appropriate for the patient. The Department will continue to publish guidelines on its website and notify providers affected through list-serves and other mechanisms, including working with provider associations to distribute notice of updates or important changes. The Department is open to additional suggestions on how best to ensure ongoing communication and network implementation strategies to assure workers receive appropriate high quality care.
- k. The Department agrees that the criteria for triggering review is broad; however, such broad criteria are necessary in order to effectively manage a network where each provider can have unique situations. The Department also agrees that adding language related to the factors the Department would rely on in a denial, such as severity, recency, frequency, repetition or any mitigating circumstances is appropriate.
- l. The Department disagrees that adding "knowingly" to using an unlicensed provider is appropriate because this is a criteria to trigger a review; such facts may not be known in

advance and fundamental to quality patient care is that providers are licensed and practicing within scope.

- m. The Department disagrees that a review criteria related to providers with a history of substance abuse is not appropriate or that the Department should not require documentation of ongoing compliance with any treatment plan because patient care can be compromised. The Department agrees that the words "public and private" should be removed.
- n. The Department agrees that informal licensure actions should not always disqualify a provider from participation in the network. The current rule proposal includes this as criteria that would trigger further review rather than a minimal qualification.
- o. The Department agrees with the Provider Network Advisory Group and other insurance industry standards that billing fraud or abuse or other significant billing irregularities is included as a criterion for review and disagrees that there must be a court finding first. The Department notes that this is not an automatic trigger for denial and the application would be further reviewed.
- p. The Department understands the concern that the broad criteria for material "complaints or allegations demonstrating a pattern of behavior or misrepresentation is broad. The Department agrees with the Provider Network Advisory Group recommendation that added both "material" and a "pattern" to the complaints criteria. The criteria are necessary in order to effectively manage a network where each provider can have unique situations. However, the Department also agrees that adding language related to the factors the Department would rely on in a denial, such as severity, recency, frequency, repetition or any mitigating circumstances is appropriate.
- q. The Department agrees that excluding any provider with any criminal history is inappropriate and did not include this criterion in minimum standards; but the Department will further review applicants with a criminal history.

**Rule Change:** The Department made 11 clarifying changes to this section: two editorial corrections, six corrections to ensure consistency with either other rule or statutory language, one clarification to simplify the text, and two clarifications based on public comment about confusion on Department intent.

**WAC 296-20-01060 Delegation of Credentialing and Recredentialing Activities**

The Department received oral and written comments related to the health care provider network delegation of credentialing, summarized below.

**Comments:**

- a. *Several commenters were concerned about the delegation of credentialing and recredentialing, either based on lack of statutory authority; concern that such delegation creates different rules or will employ an outside network that make errors with no accountability; that all agreements and the vendor selection process should be open and*

*public; that stakeholders envisioned requiring network providers to be credentialed by outside health plans which use NCQA or similar guidelines, not that the Department contract out its own credentialing process; and that delegating to groups that need credentialed would create a conflict of interest for those groups.*

**Response:**

- a. There appears to be a misunderstanding about how delegated credentialing (as opposed to enrollment) works. The Department agrees with the commenters that indicate it would be unwise to create separate networks or entities with different rules or no accountability. Delegated credentialing permits an organization, usually a large provider group, to gather and conduct the first round of validation of the individual provider information that is required by the application. These groups are required to follow NCQA or equivalent standards. The organization can also indicate that they believe the individual providers either meet or do not meet the Department standards. Using standardized information collection saves the larger groups' time as they routinely prepare this information for multiple payers and save the Department time in reviewing the applications for completeness. The Department remains responsible for making the decision to enroll into its network, according to its standards.

**Rule Change:** The Department made one clarifying change based on public comment about confusion of Department intent to emphasize that the authority to approve remains with the Department.

**WAC 296-20-01070 Waiting Periods for Reapplying to the Network**

The Department received oral and written comments related to the health care provider network waiting periods for reapplication, summarized below.

**Comments:**

- a. *One commenter indicated that ineligibility to reapply for certain reasons was not a waiting period and exceeds statutory authority.*
- b. *Several commenters requested clarification that ineligibility would not apply to providers who have been terminated from a state or federal program "for convenience"; or for any felony conviction.*
- c. *Several commenters indicated that the length of time for reapplication, five years, seems excessively long or arbitrary.*
- d. *One commenter objected to the exception for pending, minor, clerical items; indicating disagreement that pending or minor actions could be used to support denial or removal and that if a catchall is needed, the minimum standards and continuing requirements should be tightened up.*

**Response:**

- a. The Department agrees with the Provider Network Advisory Group that there are certain criteria that would make a provider ineligible and disagrees that these limited criteria are beyond its statutory authority: the statute gives the Department broad authority to effectively manage the network and the rules reflect the statute, where certain criteria, whether in minimum standards or risk of harm include or amount to permanent removal or denial.
- b. The Department agrees that clarification is needed to ensure that ineligibility would not apply to providers terminated for convenience from a government health care program.
- c. The statute directs the Department to work with the Provider Network Advisory Group on the length of this waiting period. This waiting period was unanimously approved by the provider, business, and labor representatives. The Department disagrees that the reapplication time period is excessively long or arbitrary; the denial or removal process are much more extensive than other public and private health payers, and this time period is adequate to demonstrate that the issues causing denial or removal have been resolved or remediated.
- d. The Department disagrees with removing the exception for minor or clerical issues. This was added at the request of Provider Network Advisory Group to ensure the Department had the flexibility to manage certain exceptional cases that might technically meet criteria for denial/removal, but would not meet larger goals to encourage broad access while meeting quality of care standards.

**Rule Change:** The Department made one clarifying change based on public comment to clarify that the ineligibility period does not apply to terminations for convenience.

**WAC 296-20-01080 Management of the Provider Network**

The Department received oral and written comments related to the management of the health care provider network, summarized below.

**Comments:**

- a. *One commenter was concerned that the Department had the ability to turn doctors away if they were not meeting "quality care standard" which the commenter translated to too much time loss; too many work restrictions; too many surgical referrals or MRI referrals and they will be outliers.*
- b. *One commenter requested changing the phrase "opportunity for the provider to change" to "opportunity for the provider to remediate."*
- c. *One commenter requested changing "shall" instead of "may" regarding provision of education and less severe actions.*
- d. *One commenter indicated that classic unique mitigating circumstances should include disability and chronic pain; and that the exclusion is inappropriate because these would*

*seem to be the classic mitigating circumstances and/or that prescribing for pain management should follow the new DOH regs, and/or that the rules do not account for difficulties confronted by attending physicians; especially where the problem arises because of the Departments or self-insureds conduct, not because of any inaction by the doctor leads to chronic pain; and limiting appropriate treatment to "curative or rehabilitative" care is inconsistent with the statute.*

**Response:**

- a. The Department is focused on its obligation created by statute, which includes "monitor quality of care and assure efficient management of the provider network". The Department disagrees that quality of care is defined as indicated in the comment, or not defined: expectations for quality care are set forth in the network continuing requirements; will be forthcoming in the rules or policies about the voluntary second tier, COHE expansion, and incentives for best practices; and the minimum quality of care threshold, below which a provider could be removed are set forth in the risk of harm section.
- b. The Department agrees that changing the language to "remediate" instead of "change" clarifies the intent.
- c. The Department disagrees with starting with less severe actions in each case. The Department, as stated in subsection (2) intends to consider the severity of the issue or risk of harm in deciding upon the appropriate action. The Department agrees with the Provider Network Advisory Group discussion and recommendation to preserve flexibility, because requiring a step-wise approach to each case does not afford the Department the flexibility needed to consider the circumstances of each case in order to effectively manage the network.
- d. The Department disagrees with commenters that the rules have the effect of not recognizing or discounting disability or chronic pain or other factors that could lead to poor outcomes. The Department agrees, and the rules require, the Department take into account unique mitigating circumstances. Duration of disability and chronic pain are listed as factors that on their own, ("in and of themselves") are not uniquely mitigating. The Department recognizes multiple factors can lead to poor outcomes and prohibits action for isolated incidents, or incidents where other mitigating factors were present.

**Rule Change:** The Department made eight clarifying changes to this section: seven corrections to ensure consistency with either other rule or statutory language, and one editorial correction based on public comment.

**WAC 296-20-01090 Request for Reconsideration of Department Decision**

The Department received oral and written comments related to the request for reconsideration of a Department decision, summarized below.

**Comments:**

- a) *Several commenters were concerned regarding due process for providers who are rejected or terminated from the network. They indicated that the proposed rule is unclear about the appeal rights of a health care provider whose request for reconsideration is denied and the appeal rights should be explicitly referred to.*

**Response:**

- a. The Department has consistently indicated and been advised that other statutory provisions, namely appeal rights contained in RCW 51.52 remain unaffected. The Department agrees to clarify explicitly that health care provider network decisions, such as denial or removal, are appealable under RCW 51.52

**Rule Change:** The Department made one clarifying change to indicate that the health care provider network decisions are subject to appeal under RCW 51.52.

**WAC 296-20-01100 Risk of Harm**

The Department received oral and written comments related to risk of harm, summarized below.

**Comments:**

- a. *Several commenters indicated that this section was unique and education of these requirements needs to occur to ensure that expectations are clearly communicated and or need to be monitored closely to ensure appropriate application.*
- b. *One commenter indicated that "risk of harm" language is a big step toward ensuring that all injured workers receive the best possible medical care.*
- c. *One commenter indicated that risk of harm should include treatment or coverage pursuant to a BIA or Court Order, or the standard of care for the profession because it gives an expectation that there are studies and evidence supporting every clinical decision made by a provider. Most treatment provided to a patient is largely based on "best practices" and doesn't always have high quality scientific validation as safe and effective yet this should not exclude the delivery of such care. Please make language adjustment that reference "if such care has been shown to cause injury or harm, be unsafe or ineffective".*
- d. *The dept. should not be calculating its own 'normative data on frequency'. This language would permit the dept. to create its own standards, without any real requirement for evidence, and then use those standards to limit the providers who are available to care for injured workers; using the lowest decile as a factor will eventually eliminate all providers.*

**Response:**

- a. The Department agrees that these changes are unique and represent great progress in working with the health care provider community, including the business and labor community, to ensure that injured workers are receiving high quality medical care and will not be further harmed by treatment. The Department agrees with IIMAC, who over the course of several public meetings, assisted in drafting, and unanimously approved the risk of harm language, the IICAC, who agreed with the risk of harm language; and the Provider Network Advisory Group who also approved this language. The Department agrees that clear communication and ongoing education are critical.
- b. The Department agrees that these changes are unique and represent great progress in working with the health care provider community, including the business and labor community, to ensure that injured workers are receiving high quality medical care and will not be further harmed by treatment.
- c. The Department disagrees that an explicit exception be added for treatment that is approved or provided pursuant to a BIA or Court Order. This language was approved by IIMAC and IICAC, and a majority of the provider network advisory group, including all clinicians, agreed that this specific language should not be added. The BIA and courts are reviewing and deciding on a request for a specific action in an individual case, often where such requests are exceptions. The Department complies with BIA and court orders with respect to the facts decided in that case. The risk of harm rule already prohibits the Department from taking action based on an isolated incident or case and is focused on factors that demonstrate patterns of low quality care that expose a patient to risk of harm or death. The underlying questions and the relevant determining factors are different; it is inappropriate to use a determination made in a unique case by an external entity applying its own criteria to be a bar or prohibition for the Department to review a set of activities based on the criteria set forth in this rule.
- d. The Department disagrees that it will be creating its own standards; the risk of harm rule is carefully constructed to ensure that all three elements (harm, low quality care, and a pattern) must be present and that each of those elements are defined. Establishing a pattern is a key protection for providers, requested by clinicians within IIMAC and IICAC to ensure that a poor health outcome, by itself would not be defined as harm. Requiring data is essential to that pattern, and the Department must use the data it has available; both internal and external. The Department does not intend, and the rules as written do not permit the Department to eliminate providers solely on the basis that the provision of health services is in the lowest decile; such care must also be low quality and related to harm, as defined in the rule.

**Rule Change:** The Department made no changes to this section.

# **APPENDIX**

## **A-7**

# **Department's Denial Letters**



STATE OF WASHINGTON  
DEPARTMENT OF LABOR AND INDUSTRIES  
*Tumwater Building, PO Box 44233 • Olympia, Washington 98504-4261*

December 20, 2012

Leonard H. Albert, MD  
2026 Olympic Highway North, Suite 202  
Shelton WA 98584

Dear Dr. Albert:

Thank you for your recent application to join our medical network for injured workers in Washington State.

Your application was reviewed by a credentialing committee. It failed to meet one or more professional qualifications or practice history requirements and has been denied.

Under WAC 296-20-01090, providers have the right to request reconsideration from the department. You also have the right to appeal final agency decisions under Revised Code of Washington (RCW) 51.52. **This decision will become final 60 days after you receive this notice unless a written request for reconsideration is filed with the Department of Labor and Industries or an appeal is filed with the Board of Industrial Insurance Appeals.**

Credentialing requirements are in Washington Administrative Code (WAC) 296-20-01030 and 296-20-01050. The specific area(s) your application did not meet is/are:

- **WAC 296-20-01050(3)(c)** The provider has a history of noncompliance with department of health or other state health care agency's stipulation to informal disposition (STID), agreed order, or similar licensed restriction.
- **WAC 296-20-01050(3)(j)** The provider has a history of material noncompliance with the department's rules, administrative and billing policies, evidence-based coverage decisions and treatment guidelines, and policies and other national treatment guidelines appropriate for their patient (based on severity, recency, frequency, repetition, or any mitigating circumstances)
- **WAC 296-20-01050(3)(l)** Provider has a history committing negligence, incompetence, inadequate or inappropriate treatment or lack of appropriate follow-up treatment which results in injury to a worker or creates unreasonable risk that a worker may be harmed (based on severity, recency, frequency, repetition, or any mitigating circumstances).
- **WAC 296-20-01050(3)(o)** The provider has a history of informal licensure actions, conditions, agreements, orders.
- **WAC 296-20-01050(3)(r)** **The provider has a history of material complaints or allegations demonstrating a pattern of behavior(s) or misrepresentations including, but not limited to incidents, misconduct, or inappropriate prescribing of controlled substances (based on severity, recency, frequency, repetition, or any mitigating circumstances)**

Leonard H. Albert, MD  
December 20, 2012  
Page 2

*What is the impact of this decision?* The department will not reimburse you for any on-going treatment of injured workers under your care after the effective date. You will need to assist any injured or ill worker you are currently treating in transitioning to a network provider. A list of enrolled L&I Medical Providers is available here: [www.FindADoc.Lni.wa.gov](http://www.FindADoc.Lni.wa.gov).

*What actions must the department take?* The department must notify any injured workers where you continue to be listed as the attending provider, 30 days after this notice to you, so that the injured worker has adequate time to find and transfer to a network provider. Also, upon the effective date, the department is required to report this application denial to the National Practitioner Data Bank.

*How do you request reconsideration?*

1. Your request for reconsideration must be received by the department within 60 calendar days of being notified of this decision.
2. In your request, you must:
  - a. Specify the department decision(s) that is being disputed;
  - b. State the basis for disputing the department decision;
  - c. Include any documentation to support your request.
3. The department will issue a reconsideration decision within 90 days of your request.
4. You can fax your information to 360-902-4563 or mail it to:  
Washington State Department of Labor and Industries  
Health Services Analysis  
PO Box 44261  
Olympia, WA 98504-4261

*Are you eligible to reapply to join the provider network?* Your eligibility to reapply depends on the reason for your denial and is found in WAC 296-20-01070. You are eligible to reapply to the network after five (5) years, unless you were denied from network participation due to:

- Finding of risk of harm
- Excluded, expelled or suspended, other than for convenience, from any federally or state funded programs
- Convicted of a felony or pled guilty to a felony for a crime and felony has not been expunged from the provider's record
- Sexual misconduct as defined in profession specific rules of any state or jurisdiction

If you have any questions, please feel free to contact the department at 360-902-5140 or by email at [ProvNet@Lni.wa.gov](mailto:ProvNet@Lni.wa.gov).

Sincerely,

Randal Franke, MD  
Associate Medical Director



STATE OF WASHINGTON  
DEPARTMENT OF LABOR AND INDUSTRIES  
*Tumwater Building, PO Box 44233 • Olympia, Washington 98504-4261*

February 26, 2013

Leonard H. Albert, MD  
2026 Olympic Highway North, Suite 202  
Shelton WA 98584

Dear Dr. Albert:

Your request for reconsideration of the department's decision to deny your application to participate in the department's provider network was reviewed and the department's original decision to deny your application was affirmed. The department reviewed your request, the additional information you submitted and any additional information the department acquired.

This is a final Order and Notice of the Department of Labor and Industries. **This Order is effective on March 16, 2013** (60 days after receipt of first notice). You may file a written appeal to the Board of Industrial Insurance Appeals within 60 days of receiving this decision. Appeals must be sent to the Board of Industrial Insurance Appeals, 2430 Chandler Ct SW, PO Box 42401, Olympia WA 98504.

The department will no longer reimburse you for any on-going treatment of injured workers under your care after the effective date. You will need to assist any injured or ill worker you are currently treating in transitioning to a network provider. A list of enrolled L&I Medical Providers is available here: [www.FindADoc.Lni.wa.gov](http://www.FindADoc.Lni.wa.gov).

The department will also be working with the injured workers to transition care to network providers, when needed. To help facilitate the transition, the department is sending a notice to the injured workers advising them that they need to transfer to a network provider. The notice to injured workers was mailed few days after you receive this notice. The department is required to report this application denial to the National Practitioner Data Bank.

If you have any questions, please feel free to contact the Gary Walker, MA, MPA, at 360-902-6823 or at department at 360-902-5140 or by email at [walg235@Lni.wa.gov](mailto:walg235@Lni.wa.gov).

Sincerely,

Handwritten signature of Gary M. Franklin in cursive script.

Gary Franklin, MD  
Medical Director



STATE OF WASHINGTON  
DEPARTMENT OF LABOR AND INDUSTRIES  
Tumwater Building, PO Box 44233 • Olympia, Washington 98504-4261

January 29, 2013

Jeff L. Summe, DO  
7614 195<sup>th</sup> ST SW  
Suite 200  
Edmonds WA 98026

Dear Dr. Summe:

Thank you for your recent application to join our medical network for injured workers in Washington State.

Your application was reviewed by a credentialing committee. It failed to meet one or more professional qualifications or practice history requirements and has been denied.

Under WAC 296-20-01090, providers have the right to request reconsideration from the department. You also have the right to appeal final agency decisions under Revised Code of Washington (RCW) 51.52. **This decision will become final 60 days after you receive this notice unless a written request for reconsideration is filed with the Department of Labor and Industries or an appeal is filed with the Board of Industrial Insurance Appeals.**

Credentialing requirements are in Washington Administrative Code (WAC) 296-20-01030 and 296-20-01050. The specific area(s) your application did not meet is/are:

- WAC 296-20-01050(3)(j) Materially noncompliant with the department's rules, administrative and billing policies, evidence-based coverage decisions and treatment guidelines, and policies and other national treatment guidelines appropriate for their patient (based on severity, recency, frequency, repetition, or any mitigating circumstances)
- WAC 296-20-01050(3)(l) Committed negligence, incompetence, inadequate or inappropriate treatment or lack of appropriate follow-up treatment which results in injury to a worker or creates unreasonable risk that a worker may be harmed (based on severity, recency, frequency, repetition, or any mitigating circumstances)
- WAC 296-20-01050(3)(q) Engaged in billing fraud or abuse or has a history of other significant billing irregularities

*What is the impact of this decision?* The department will not reimburse you for any on-going treatment of injured workers under your care after the effective date. You will need to assist any injured or ill worker you are currently treating in transitioning to a network provider. A list of enrolled L&I Medical Providers is available here: [www.FindADoc.Lni.wa.gov](http://www.FindADoc.Lni.wa.gov).

Jeff L. Summe, DO  
January 29, 2013  
Page 2

*What actions must the department take?* The department must notify any injured workers where you continue to be listed as the attending provider so the injured worker has adequate time to find and transfer to a network provider. This notice will be mailed to the injured workers 30 days from now unless the department receives your written request for reconsideration prior to then. If we receive written request for reconsideration, the department will hold the letter pending outcome of the reconsideration.

Also, upon the effective date, the department is required to report this application denial to the National Practitioner Data Bank.

*How do you request reconsideration?*

1. Your request for reconsideration must be received by the department within 60 calendar days of being notified of this decision.
2. In your request, you must:
  - a. Specify the department decision(s) that is being disputed;
  - b. State the basis for disputing the department decision;
  - c. Include any documentation to support your request.
3. The department will issue a reconsideration decision within 90 days of your request.
4. You can fax your information to 360-902-4563 or mail it to:  
Washington State Department of Labor and Industries  
Health Services Analysis  
PO Box 44261  
Olympia, WA 98504-4261

During reconsideration the department will consider any new information you provide, and other new information received by the department since the decision was made in conjunction with the initial information the department had initially.

*Are you eligible to reapply to join the provider network?* Your eligibility to reapply depends on the reason for your denial and is found in WAC 296-20-01070. You are eligible to reapply to the network after five (5) years, unless you were denied from network participation due to:

- Finding of risk of harm
- Excluded, expelled or suspended, other than for convenience, from any federally or state funded programs
- Convicted of a felony or pled guilty to a felony for a crime and felony has not been expunged from the provider's record
- Sexual misconduct as defined in profession specific rules of any state or jurisdiction

If you have any questions, please feel free to contact the department at 360-902-5140 or by email at [ProvNet@Lni.wa.gov](mailto:ProvNet@Lni.wa.gov).

Sincerely,

Randal Franke, MD  
Associate Medical Director



RECEIVED  
APR 15 2013

STATE OF WASHINGTON  
DEPARTMENT OF LABOR AND INDUSTRIES  
*Tumwater Building, PO Box 44261 • Olympia, Washington 98504-4261*

April 12, 2013

Jeff L. Summe, DO  
7614 195<sup>th</sup> ST SW  
Suite 200  
Edmonds WA 98026

Dear Dr. Summe

Your request for reconsideration of the department's decision to deny your application to participate in the department's provider network was reviewed and the department's original decision to deny your application was affirmed. The department reviewed your request, the additional information you submitted and any additional information the department acquired.

**This is a final Order and Notice of the Department of Labor and Industries. The effective date of this Order is the date you receive this letter. You may file a written appeal to the Board of Industrial Insurance Appeals within 60 days of receiving this decision. Appeals must be sent to the Board of Industrial Insurance Appeals, 2430 Chandler Ct SW, PO Box 42401, Olympia WA 98504.**

The department will no longer reimburse you for any on-going treatment of injured workers under your care after the effective date. You will need to assist any injured or ill worker you are currently treating in transitioning to a network provider. A list of enrolled L&I Medical Providers is available here: [www.FindADoc.Lni.wa.gov](http://www.FindADoc.Lni.wa.gov).

The department will also be working with the injured workers to transition care to network providers, when needed. To help facilitate the transition, the department is sending a notice to the injured workers advising them that they need to transfer to a network provider. The notice to injured workers will be mailed few days after you receive this notice. The department is required to report this application denial to the National Practitioner Data Bank.

If you have any questions, please feel free to contact Gary Walker, MA, MPA, at 360-902-6823 or by email at [walg235@Lni.wa.gov](mailto:walg235@Lni.wa.gov).

Sincerely,

Gary Franklin, MD  
Medical Director

cc: Randolph I. Gordon

# **APPENDIX**

## **A-8**

# **Response to Denial Letters**

LEONARD ALBERT MD., Ph.D., PLLC  
INTERNAL MEDICINE, PAIN MANAGEMENT, ANESTHESIS  
Ph: (360)432-1234 Fax: (360)432-2343  
2026 Olympic Hwy. North, Suite 202  
P.O. Box 698 / Shelton, WA 98584

DOCKET NO. 13 P 1031

January 29, 2013

Department Of Labor and Industries  
Health Services Analysis  
P.O. Box 44261  
Olympia, WA 98504-4261

January 29, 2013

Response to L & I. regarding denial of application for medical network for injured workers in Washington state.  
Letter dated 12/20 2012, but received 1/16/2013.

Dear Credentialing Committee:

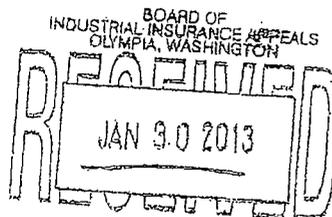
I protest your denial of my joining the medical network for injured workers in Washington state. This is based on a Washington state Supreme Court decision in the Nguyen versus Washington State Medical Quality Assurance Commission. None of my patients have been materially harmed and most have benefited from the therapy I have prescribed.

I am enclosing a copy of my curriculum vitae to demonstrate my expertise in the area of narcotic prescriptions and drug abuse.

Sincerely,



Leonard Albert M.D., PhD  
Cc: Board of Industrial Insurance Appeals



1983-1985: Medical Director, Therapeutic Health Services, a licensed drug abuse treatment center, Seattle, WA

1982-present: Lecturer for CME courses in Pharmacology of Depression and Pain Management

1982-1983: Staff Physician, Therapeutic Health Services, Seattle WA

1982: Instructor, Pharmacology of Substance Abuse, Seattle University, Seattle, WA

1981-1982: Internal Medicine, private practice, Seattle, WA

1980-1981: Associate Director, Sanford University Pain Center, Stanford, CA

1980-1981: Physician Scientist, Dept. of Clinical Pharmacology, Stanford Univ., Stanford CA

#### CERTIFICATIONS

1986: American Board of Anesthesiology

1980: American Board of Internal Medicine

1977: National Board of Medical Examiners

#### LICENSURE

Washington # 252090015840

#### COMMITTEES

1998-2000: Co-Chief, ICU, Mason General Hospital, Shelton WA

1998-2000: Chief of Medicine, Mason General Hospital, Shelton WA

1996-1998: Chairman, Pharmacy and Therapeutics Committee, Mason General Hospital, Shelton WA

1986-1992: Pharmacy and Therapeutics Committee, Capital Medical Center, Olympia, WA

1983-1985: Professional Review Organization of Washington

Dent, R.; Guillaminault, C.; Albert, L.; Posner, B.; Cox, B.; and Goldstein, A. "Diurnal Rhythm Of Plasma Immunoreactive Beta-Endorphin and its Relationship to Sleep Stages and Plasma Rhythms of Cortisol and Prolactin." J. Clin. Endocrin. And Metabol., **52**:942-7, 1981

Albert, L. "Newer Potent Analgesics" Rational Drug Therapy **16**:1-6, 1982

Grevert, P.; Albert, L. and Goldstein, A. "Physiological and Psychological Effects of an Eight Hour Infusion of Naloxone in Normal Men" Biol. Psychiatry **18**:1375-92, 1983

Spiegel, D.; Albert, L.H. "Naloxone fails to reverse hypnotic alleviation of chronic pain" Psychopharmacology (Berl) **1983**;81 (2): 140-3

Albert, L. "Analgesic Agents that Act Centrally to Modify Pain" in **Controversies in Rheumatology** R. Willkens, ed. Grune and Stratton, New York, 1987

Hecker, B. and Albert, L. "Patient-Controlled Analgesia" Pain **35**:115-120; 1988

# **APPENDIX**

## **A-9**

# **Department's notice to National Practitioner Data Bank**

**From:** [Wharton, Angela J \(LNI\)](mailto:Wharton,Angela.J@LNI)  
**To:** [LNI RE Public Records Mailbox](mailto:LNI.RE.Public.Records.Mailbox)  
**Subject:** FW: Public Records Request #94359  
**Date:** Wednesday, July 24, 2013 12:46:04 PM

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*Angie Wharton*

*Public Records Unit*

*Dept. of Labor and Industries*

*Email requests to: [PublicRecords@LNI.wa.gov](mailto:PublicRecords@LNI.wa.gov)*

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**From:** Shawn Newman [<mailto:newmanlaw@comcast.net>]  
**Sent:** Wednesday, July 24, 2013 11:16 AM  
**To:** Wharton, Angela J (LNI)  
**Cc:** Throgmorton, Michael (ATG)  
**Subject:** RE: Public Records Request #94359

Thank you. I noted in the termination letter states at page 2 under What actions must the department take? that "The department must notify any injured workers where you continue to be listed as the attending provide so the injured worker can transfer to a network provider. ... The Department is also required to notify the National Practitioner Data Bank of this decision." As a follow up to my PRR, I am requesting copies of the notice LNI sends to injured workers and the National Practitioner Data Bank. I would like the form letter (if there is one) and any such letters sent out regarding Dr. Leonard Albert, M.D.

I would also like to see any communications between LNI and the Medical Quality Assurance Commission regarding LNI's consideration of MQAC probationary orders in the credentialing process. Specifically, I understand from MQAC that LNI considered MQAC probation rulings as an aggravating factor in determining whether or not to allow a physician to become a member of the Network. I further understand that MQAC disagreed with that characterization.

---

**From:** Wharton, Angela J (LNI) [<mailto:WHAA235@LNI.WA.GOV>]  
**Sent:** Wednesday, July 24, 2013 10:16 AM  
**To:** [newmanlaw@comcast.net](mailto:newmanlaw@comcast.net)  
**Cc:** Throgmorton, Michael (ATG)  
**Subject:** Public Records Request #94359

Dear Mr. Newman,

Attached you will find a copy of three termination letters in response to item #2 a c<sup>f</sup> your public records request received on July 16, 2013. We have searched our records and found that we do not

## Shawn Newman

---

**From:** Mitchell, Bonnie J (LNI) <mitb235@LNI.WA.GOV>  
**Sent:** Tuesday, August 27, 2013 4:11 PM  
**To:** newmanlaw@comcast.net  
**Subject:** Public Records Request ID 94988

Dear Mr. Newman:

Here are the steps when a HIPDB report is to be submitted for denial into the provider network. These are steps for all reports.

- 1) Look in the provider's electronic file to check status and dates.
- 2) Sign into the Data Bank and go into the Reporting Service to draft the Report.
- 3) I copy the pertinent biographical data as well as the date of action and effective date of denial from the provider's electronic file and paste into the HIPDB report template.
- 4) The type of adverse action is Government Administrative.
- 5) The adverse action classification is: Denial of initial application.
- 6) I enter the following text into the field for Basis of action: "Does not meet Dept credentialing requirements"
- 7) The length of action is 'Indefinite'
- 8) Is the subject automatically reinstated after adverse action period is complete: 'No'.
- 9) The following text is added into the field 'Reasons for Action': "Failed to meet department credentialing requirements as specified in Washington Administrative Code."

Once the form is completed it is submitted to HIPDB

This completes my response and closes this request. If I can be of further assistance, please let me know.

Sincerely,

*Bonnie Mitchell*

Bonnie Mitchell  
Public Records Unit  
Dept. of Labor and Industries  
PO Box 44632  
Olympia WA 98504-4632  
Phone: 360-902-4404  
Fax: 360-902-5529  
Email requests to: [PublicRecords@LNI.wa.gov](mailto:PublicRecords@LNI.wa.gov)

# **APPENDIX**

## **A-10**

### **Findings of Fact, Conclusions of Law, and Order Denying Plaintiff's Motion for Declaratory Relief**

~~Proposed~~  
(MT)

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BOARD OF INDUSTRIAL INSURANCE APPEALS  
OF THE STATE OF WASHINGTON

LEONARD ALBERT, MD, PHD, AN  
INDIVIDUAL, AND JEFF SUMME, DO,  
AN INDIVIDUAL,

PLAINTIFFS,

v.

STATE OF WASHINGTON,  
DEPARTMENT OF LABOR &  
INDUSTRIES,

DEFENDANT.

Provider No.

Docket No. 13-2-01677-7

PROPOSED FINDINGS OF FACT,  
CONCLUSIONS OF LAW, AND  
ORDER DENYING PLAINTIFFS'  
MOTION FOR DECLARATORY  
JUDGMENT

*[Handwritten initials]*  
(MT)

*[Handwritten initials]*  
(MT)

This matter came on before HONORABLE JUDGE ~~CHRISTOPHER WICKHAM~~ *GARY TABOR* in

open court on November 19, 2013 on Plaintiffs' Motion for a Declaratory Judgment. Plaintiff  
LEONARD ALBERT, MD, PhD appeared by his counsel, SHAWN NEWMAN. Plaintiff  
JEFF SUMME, DO appeared by his counsel RANDOLPH I. GORDON. The Defendant  
DEPARTMENT OF LABOR AND INDUSTRIES appeared by its counsel, ROBERT W.  
FERGUSON, Attorney General, per MICHAEL THROGMORTON, Assistant Attorney  
General. The court reviewed the records and files herein, including the declarations of

~~RCW 51.52.075 DOES NOT APPLY~~

1 Gary Franklin, MD, Leah Hole-Marshall, Randal Franke, MD, Kaylynn What, Leonard Albert,  
2 Jeff Summe, Shawn Newman, and Randolph Gordon, and the exhibits attached thereto. The  
3 court also considered the briefs submitted by counsel and heard the argument of counsel.  
4 Therefore, being fully informed, the court makes the following:

5  
6 **I. FINDINGS OF FACT**

7 1.1 In 2011, the Washington State Legislature amended RCW 51.36.010, creating the  
8 Medical Provider Network. The legislature empowered the Department of Labor and  
9 Industries to promulgate rules governing the admission, oversight, suspension,  
10 termination and denial of providers who applied to join the Network.

11 1.2 Plaintiffs applied to join the Medical Provider Network and were denied admission.

12 1.3 The Department of Labor and Industries has not issued any order "terminating"  
13 Plaintiffs' authority to treat and to bill for treatment of injured workers in Washington  
14 within the meaning of RCW 51.52.075  
15

16 Based on the foregoing findings of fact, the Court now makes the following:

17 **II. CONCLUSIONS OF LAW**

18 2.1 This Court has jurisdiction over the parties and the constitutional issue raised by  
19 Plaintiffs. This Court does ~~not~~ have jurisdiction to consider Plaintiffs' argument that  
20 RCW 51.52.075 is applicable to decisions of the Department of Labor and Industries to  
21 deny their applications to join the Medical Provider Network created under the 2011  
22 amendments to RCW 51.36.010.  
23

24 2.2 ~~Plaintiffs have not shown entitlement to admission to the Medical Provider Network~~  
25 ~~created under the 2011 amendments to RCW 51.36.010.~~

26 **RCW 51.52.075 DOES NOT APPLY**  
PROPOSED ORDER DENYING PLAINTIFFS'  
MOTION FOR DECLARATORY JUDGMENT **TO DENIAL OF**  
**ELIGIBILITY TO PARTICIPATE IN THE**  
**MEDICAL PROVIDER NETWORK.**

ATTORNEY GENERAL OF WASHINGTON  
Labor & Industries Division  
7141 Cleanwater Drive SW  
PO Box 40121  
Olympia, WA 98504-0121  
(360) 586-7707  
FAX: (360) 586-7717

(H) *[Handwritten initials]*

*[Handwritten initials]*

*[Handwritten initials]*

OR VESTED RIGHT

*[Handwritten initials]*

1 2.3 Plaintiffs do not have a constitutional liberty interest in treating injured workers.

2 ~~2.4 Plaintiffs do not have a constitutional property interest in treating injured workers.~~

3 ~~2.5 Plaintiffs have failed to establish a legitimate expectation of entitlement to admission to~~  
4 ~~the Medical Provider Network created under the 2011 amendments to RCW 51.36.010.~~

5 ~~2.6 Plaintiffs do not have a due process right to a pre-deprivation hearing on the state's~~  
6 ~~decision to deny their applications to join the Medical Provider Network.~~

*[Handwritten initials]*

*[Handwritten initials]*

7  
8 Based on the foregoing Findings of Fact and Conclusions of Law, IT IS ORDERED  
9 that Plaintiffs' Motion for a Declaratory Judgment is DENIED.

10 DATED THIS 11<sup>th</sup> day of November, 2013.

*[Signature]*  
JUDGE CHRISTOPHER WICKHAM  
*[Signature]*  
Gary Tabor

14 Presented by:  
15 ROBERT W. FERGUSON  
16 Attorney General

17 *[Signature]*  
18 MICHAEL J. THROGMORTON  
19 Assistant Attorney General  
20 WSBA No. 44263

21 Approved as to form by:

22 *[Signature]*  
23 SHAWN NEWMAN, WSBA #14193  
24 Attorney for Plaintiff Leonard Albert

25 *[Signature]*  
26 RANDOLPH GORDON, WSBA #8435  
Attorney for Plaintiff Jeff Summe

RECEIVED  
SUPREME COURT  
STATE OF WASHINGTON  
2014 JAN 21 A 11: 26  
BY RONALD R. CARPENTER  
CLERK

SUPREME COURT FOR THE STATE OF WASHINGTON

LEONARD ALBERT, M.D., Ph.D., an individual, and JEFF SUMME, D.O, an individual,

Plaintiffs/Appellants,

v.

STATE OF WASHINGTON,  
DEPARTMENT OF LABOR &  
INDUSTRIES,

Defendant/Respondent.

SUPREME COURT

NO. 89664-0

CERTIFICATE OF SERVICE  
BRIEF OF APPELLANTS

I declare, under penalty of perjury, under the laws of the State of Washington that on this date, I caused to be served a copy of the Brief of Appellants on:

Michael J. Throgmorton, Assistant Attorney General  
Kaylynn What, Assistant Attorney General  
Katy Dixon, Assistant Attorney General  
Office of the Attorney General, Labor & Industries Division,  
7141 Cleanwater Drive SW, Olympia, WA 98504-0121  
PH: (360) 586-7707

Dated: 1/21/14

  
Shawn Newman, WSBA 14193  
Attorney for Plaintiff Dr. Leonard Albert